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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by hospital facilities as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Electronic and paper claims billing.
- Claims payment.
- Prior authorization (PA).
- Inpatient policy.
- Outpatient policy.
- Administratively necessary days (AND).
- Exclusions.
- Accommodation revenue codes.
- Ancillary revenue codes.
- Ambulatory surgical centers (ASC) surgical procedures.
- Hospital owned and operated ambulance services.

3.1.2 Swing Beds

For those hospitals that meet the Code of Federal Regulation requirements and that are approved by the Centers for Medicare and Medicaid Services (CMS) to provide swing bed care, a separate provider number is needed for reimbursement from the Idaho Medicaid Program. When an application has been approved, the provider will receive a *Long-Term Care Facility Handbook* that explains the billing requirements particular to swing beds.

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type **131**) and settled on a cost basis with other outpatient services. Prescription drugs must be billed on the outpatient pharmacy claim form.

3.1.3 Payment

Medicaid pays the billed charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient diagnostic laboratory procedures, which are subject to the Medicaid pricing file, are paid at or below Medicare's prevailing rate.
- Diagnostic radiology services, ASC services, and other ancillary services paid on a Medicaid fee schedule and are subject to the hospital's interim rate. For these services, a combination of the fee schedule and actual costs will be determined as payment at cost settlement.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, guidelines must be followed to ensure reimbursement for providing Medicaid covered services. Inpatient and outpatient services will require a referral from the HC primary care provider (PCP).

See *Section 1.5 Healthy Connections (HC), General Provider and Participant Information*, for information on HC.

http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3438/DesktopDefault.aspx

3.1.4 Type of Bill Codes

Enter one of the following codes in field **4** on the UB-04 claim form. Use the code that best describes your claim:

111 Hospital inpatient (Part A), admit through discharge.

112 Hospital inpatient (Part A), interim first claim.

113 Hospital inpatient (Part A), interim continuing claim.

114 Hospital inpatient (Part A), interim last claim.

117 Hospital inpatient (Part A), replacement of prior claim (electronic claims only).

118 Hospital inpatient (Part A), void/cancel of a prior claim (electronic claims only).

121 Hospital inpatient (Part B), admit through discharge.

122 Hospital inpatient (Part B), interim first claim.

123 Hospital inpatient (Part B), interim continuing claim.

124 Hospital inpatient (Part B), interim last claim.

127 Hospital inpatient (Part B), replacement of prior claim.

128 Hospital inpatient (Part B), void/cancel of a prior claim.

131 Hospital outpatient, admit through discharge.

137 Hospital outpatient, replacement of prior claim.

138 Hospital outpatient, void/cancel of a prior claim.

141 Hospital other (Part B), admit through discharge.

151 Hospital intermediate care (level 1), admit through discharge.

721 Clinic (hospital based or independent renal dialysis center) admit through discharge end stage renal disease (ESRD).

722 Clinic (hospital based or independent renal dialysis center) interim first claim (ESRD).

723 Clinic (hospital based or independent renal dialysis center) interim continuing claim (ESRD).

724 Clinic (hospital based or independent renal dialysis center) interim last claim (ESRD).

831 Hospital ASC surgery (ASC services to hospital outpatient) admit through discharge.

837 Hospital ASC surgery (ASC services to hospital outpatient) replacement of prior claim.

838 Hospital ASC surgery (ASC services to hospital outpatient) void/cancel of prior claim.

3.1.4.1 Type of Bill Codes for Outpatient Medicare Crossovers Only

Use one of the following types of bill codes for outpatient Medicare crossover claims.

135 Hospital outpatient, late charge only.

137 Hospital outpatient, replacement of a prior claim.

851 Critical access hospital, admit through discharge.

3.1.5 Patient Status Codes

Enter one of the following codes in field **17** on the UB-04 claim form.

01 Discharged to home or self care (routine discharge).

02 Discharged/transferred to another short-term general hospital.

03 Discharged/transferred to skilled nursing facility (SNF).

04 Discharged/transferred to an intermediate care facility (ICF).

05 Discharged to another type of institution (including distinct part) or referred to another institution.

06 Discharged/transferred to home under care of organized home health service organization. (indicate in field **84** the status or location of the participant and time they left the hospital).

07 Left against medical advice or discontinued care.

08 Discharged/transferred to home under care of a home IV drug therapy provider.

20 Expired (or did not recover).

30 Still a patient or expected to return for outpatient services.

40 Hospice, expired at home.

41 Hospice, expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice.

42 Hospice, expired, place unknown.

43 Discharged/transferred to a federal health care facility.

3.2 Inpatient Hospital Service Policy

3.2.1 Overview

Medicaid pays for inpatient services ordinarily furnished in a hospital for the care and treatment of a patient under the direction of a physician or, under certain circumstances, a dentist.

3.2.2 Inpatient Day

An inpatient day is counted for:

- A patient who is admitted to the hospital for inpatient services, intends to stay overnight, and is in the inpatient bed at the midnight census hour.
- A patient who is admitted for observation in a routine service, has stayed 24 hours, and is not ready to be discharged.

3.2.3 Reimbursement

Medicaid pays billed inpatient charges multiplied by an inpatient reimbursement rate. Medicaid establishes an upper reimbursement limit based on cost audit settlement set by Medicaid. Payment will not exceed this limit.

3.2.4 Accommodation Rates

3.2.4.1 Limitations

Birthing room charges should reflect the normal administrative, nursing, and physical resources utilized for the mother and child occupying the same room. Ancillary services may not be combined with the charge for the accommodation.

Private and psychiatric accommodations will not be reimbursed at more than the semiprivate room rates on file with Medicaid except as stated in, *Section 3.2.4.2 Exceptions*.

If the participant is placed in a private room for the hospital's convenience, Medicaid will pay the semiprivate room rate only. The participant must not be billed for the amount in excess of the semiprivate rate.

3.2.4.2 Exceptions

Payment is limited to a semiprivate room accommodation rate; however, when the physician writes an order for a private room or isolation for the participant because of medical necessity, Medicaid will pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form.

3.2.4.3 Rate Changes

All changes in accommodation rate charges must be submitted to Medicaid on the hospital accommodation and room rate schedule form in, *Section 3.2.8 Hospital Accommodation Rate Schedule*. Please make note of the revenue codes that require an accommodation rate listed in *Section 3.7.2 Accommodation Revenue Codes*.

Note: All inpatient services and charges for the same revenue code on the same date of service, same billed amount, should be combined and billed on the same line of the UB-04 claim form or in the appropriate field of the electronic claim form.

3.2.5 Mental Health Hospital

Payment for inpatient services provided in a freestanding mental health hospital is limited to hospitals contracted with the Department of Health and Welfare (DHW) under the authority of the Division of Family and Community Services serving participants less than 21 years of age. Limited outpatient hospital therapy benefits may be provided under revenue codes **914**, **915**, **916**, and **918**. Inpatient mental health services require prior authorization (PA) and must be under the direction of a physician in a facility

accredited by the joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which it provides services.

The Department of Health and Welfare will pay for medically necessary in-patient psychiatric services for participants under 21 years of age that have a DSM IV diagnosis with substantial impairment in thought, mood, perception, or behavior. Both severity of illness and intensity of services criteria must be met for admission.

The Department of Health and Welfare or its designee must authorize admissions. Admission to an Institute for Mental Disease (IMD) for participants under age 21 requires a pre-admission review prior to an elective admission, which is defined as an admission that is planned and scheduled in advance, and is not an emergency in nature.

Emergency admissions require authorization within one workday of the admission. An emergency for purposes of admission is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part of the individual, death or harm to the individual, or death or harm to another person.

The hospital medical record of the admission must include documentation to support that the participant's status upon admission meets the definition of an emergency as stated above. Requests for authorization of emergency admissions must include the same information as required for elective admissions.

The Department of Health and Welfare or its designee will establish the initial length of stay. An individual plan of care must be developed and implemented within 72 hours of admission. The plan of care must improve the participant's condition to the extent that acute psychiatric care is no longer necessary.

A hospital may request a continued stay review from DHW or its designee, but it must be no later than the date assigned by DHW or its designee. A plan of care must include documentation to support that treatment of the participant's psychiatric condition continues to require services that can only be provided on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease.

Note: Failure to request a pre-admission or continued stay review in a timely manner will result in a retrospective review conducted by DHW or its designee.

3.2.5.1 Penalties

HOSPITAL Penalty:

One day late	$260
Two days late	$520
Three days late	$780
Four days late	$1,040
Five or more days late	$1,300

PHYSICIAN - Penalty for Admitting Physician:

One day late	$50
Two days late	$100
Three days late	$150
Four days late	$200
Five or more days late	$250

3.2.6 Diagnostic Tests and Procedures

Physician ordered, medically necessary, diagnostic tests, and procedures related to the diagnosis and treatment of the participant's medical condition(s) are reimbursable. Those tests and procedures include, but are not limited to:

- Laboratory tests.
- Pathology tests.
- Diagnostic radiology procedures.
- Admission tests.

Some procedures may require PA. See *Section 3.4 Prior Authorization (PA)*, for more information.

3.2.7 Billing Procedures

3.2.7.1 Medicare Crossover Participants

When a participant has Medicare coverage, the hospital must bill Medicare first.

Part A claims do not automatically cross over from Medicare, so it is necessary to bill Medicaid on the UB-04 claim form, with the Medicare Explanation of Benefits (EOB) attached, or electronically with PES or another vendor's software. Part B claims should automatically cross over from Medicare to Medicaid. If this does not happen, you can bill Medicaid electronically with the Medicare information.

When a participant has Part A Medicare only, it is not necessary to bill Medicare for Part B services. Bill Medicaid directly for the Part B services and indicate on the paper claim in field **80** of the UB-04 claim form that the participant has Part A only. Examples of Part B services would include lab work and emergency department services.

See *Section 2.5 Crossover Claims*, *General Billing*, for billing instructions.

3.2.7.2 Birth/Delivery Billing

When submitting a claim for the delivery of a child, the charges for both the mother and the child can be billed on one claim form with the mother's Idaho Medicaid identification (MID) number only if both leave the hospital at the same time. Combine all charges for like revenue codes.

If either mother or child remains in the hospital, the claims must be billed separately and the child's services cannot be billed using the mother's MID number. If the child is admitted to the neonatal intensive care unit (NICU) anytime during the stay, the charges may not be combined with the mother's and must be billed separately.

3.2.7.3 Pregnancy Services

The Pregnant Women (PW) Program is restricted to pregnancy related services only.

See *Section 1.4.4 Pregnant Women (PW)*, *General Provider and Participant Information*, for more information.

3.2.7.4 Split Billing

When billing, a participant's charges must occasionally be split out and billed on separate claims. Instances when a split billing would occur include:

- Change in participant program eligibility.
- Inpatient stays that span the hospital fiscal year end.
- Portions of an inpatient stay which have been denied by the Quality Improvement Organization (QIO) or Idaho Medicaid.

- Inpatient stays that reflect transfers to psychiatric or rehabilitation units assigned a different Medicaid provider number than the general hospital.
- Inpatient discharges in which administratively necessary days (AND) are billed on an outpatient claim.
- Hospital owned and operated ambulance services must be billed on a separate UB-04 claim form using type of bill **131**.

Any inpatient claim submitted with a statement, Through Date that is less than the discharge date must have a patient status of **30** to indicate that this is an interim billing.

Use Medicaid Automated Voice Information Service (MAVIS) to verify changes in a participant's eligibility. Call MAVIS at: **(208) 383-4310 in the Boise calling area** or **(800) 685-3757 (toll free)**.

For additional information regarding participant eligibility, choose option 1. The automated system is available 24 hours a day. Provider representatives are available Monday through Friday from 8 a.m.– 6 p.m. MT (excluding state holidays).

3.2.7.5 Multiple Rates

When multiple rates exist for the same accommodation revenue code, a separate revenue line should be used to report each rate and the same revenue code should be reported on each line. Failure to split out these multiple rates will result in payment at the lower rate.

3.2.7.6 Donor/Transplants

Donor costs for bone, heart, liver, and kidney transplants should be billed using the participant's name and Medicaid identification (MID) number. Enter *Donor Charges* in the Remarks field of the claim form to prevent a denial of the claim as a duplicate. A liver transplant from a live donor is not covered by Medicaid.

3.2.8 Hospital Accommodation Rate Schedule

A copy of the hospital Accommodation and Room Rate Schedule form is available in *Appendix D; Forms* or by contacting EDS.

Contact an EDS provider enrollment representative through MAVIS (option 0, option 4) at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

The automated system is available 24 hours a day. Provider representatives are available Monday through Friday from 8 a.m. – 6 p.m. MT (excluding state holidays).

Return the form to:

EDS
Provider Enrollment
PO Box 23
Boise, ID 83707
Fax: (208) 395-2198

3.3 Outpatient Hospital Service Policy

3.3.1 Overview

Outpatient services are services performed in the hospital for a participant who does not require inpatient accommodations. The items or services must be medically necessary and performed by or under the direction of a physician, or under certain circumstances, a dentist.

Outpatient services are to be provided at a service location over which the hospital exercises financial and administrative control. Financial and administrative control means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill, and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (*e.g.*, from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or 35 miles from a rural hospital).

Outpatient services can include the following:

- Preventative.
- Diagnostic*.
- Admission tests.
- Therapeutic.
- Rehabilitative.
- Palliative.
- Laboratory [PA.]
- Pathological [PA].

[PA] Some services require prior authorization (PA) by the Department of Health and Welfare (DHW). See *Section 3.4 Prior Authorization (PA)*, for more information.

* Radiology services must include the **TC** modifier.

Note: All similar revenue codes with the same dates of service, with the exception of revenue codes requiring CPT procedure codes, should be billed on one line of the outpatient claim form or the electronic claims screen.

The following revenue codes require the appropriate CPT or HCPCS procedure code and modifier combinations:

300 – 307	**561**	**821**
320 – 324	**569**	**831**
340 – 341	**610 - 618**	**841**
350 – 352	**634 - 636**	**851**
400 – 404	**657**	**924**
550	**771**	**942**

3.3.2 Reimbursement

Medicaid pays the covered charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient laboratory procedures, which are subject to the Medicaid pricing file, are paid at 62 percent of Medicare's prevailing rate.
- Diagnostic radiology services, ambulatory surgical center (ASC) services, and other services are paid at the Medicaid fee schedule rate on an interim basis. For these services, a combination of the fee schedule and actual costs will determine a blended rate for payment at cost settlement.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

3.3.3 Outpatient Observation

Observation should be billed under the revenue code that reflects the service area in which the provider accounts for the participant and the related costs (inpatient room, outpatient room, or emergency room).

When a participant is observed in an inpatient bed by staff assigned to the routine care area, revenue code **760** or **762** should be used to reflect the costs of the routine service area. Any participant, who is in observation status in a routine service area after 24 hours, must be admitted at the beginning of the twenty-fifth hour.

Observation in a designated room or not in an inpatient bed should be billed under revenue code **760** or **762**.

Observation room and time may not be billed as a substitute for an emergency department visit or nursing services rendered outside the emergency department.

Observation time cannot be substituted for stays denied by the Quality Improvement Organization (QIO) when the intensity of services does not justify an inpatient day.

3.3.4 Professional Component

Medicaid has an arrangement with Medicare for the automatic billing by magnetic tape of additional coverage amounts for shared Medicare Part B and Medicaid participants. Hospital services related to the professional component of all ancillary services that are submitted to Medicare are automatically submitted, processed, and forwarded to Medicaid. If the participant is not dually eligible then the professional component of all ancillary services must be billed to the Idaho Medicaid Program by the performing provider.

See *Section 2.5 Crossover Claims*, *General Billing Information*, for more information.

3.3.5 Presumptive Eligibility (PE) and Pregnant Women (PW) Clinic

Presumptive eligibility participants are only eligible for outpatient pregnancy related services. Some hospitals and district health departments are PW clinics. They must be a Medicaid approved provider and meet the conditions for PE or PW. Additionally, approved providers must be trained and certified by DHW. For more information on the training process, please contact your local DHW eligibility office.

See *Section 1.4.3 Presumptive Eligibility (PE)*, *General Provider and Participant Information*, for more information.

3.3.6 Physical Therapy (PT), Occupational Therapy (OT), and Speech-Lauguage Pathology (SLP) Services

3.3.6.1 Overview

Medicaid covers the following physician-ordered therapy services:

- Medically necessary SLP services provided by a licensed SLP.

- Medically necessary PT and OT services when provided by or under the supervision of a licensed therapist.

Services must be part of a plan of care (POC) based on a physician order. The participant's progress must be reviewed and the POC updated and reordered every 30 days by the physician or midlevel practitioner. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy necessary for more than six months; then an order for continued care is required every six months.

The written physician's order must stipulate the type of services to be provided, the frequency of treatment, the expected duration of therapy, and the anticipated outcomes along with the physician's/midlevel signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

3.3.6.2 Supervision

Services provided by OT and PT Assistants may be billed to Medicaid when general supervision by the appropriate professional is provided in the hospital outpatient setting. General supervision requires direct, on-premises contact between the therapist, the therapy assistant, and the participant at least every five visits, or at least once a week if seen on a daily basis. The supervising therapist is required to cosign documentation signed by the assistant.

Services provided by SLP assistants are considered to be unskilled services, and will be denied as not medically necessary if billed as SLP services.

3.3.6.3 Limitations

- PT visits are limited to 25 visits per calendar year regardless of the billing provider.
- OT visits are limited to 25 visits per calendar year regardless of the billing provider.
- Speech-language pathology visits are limited to 40 visits per calendar year regardless of the billing provider.

If additional visits are medically necessary, the provider must obtain prior authorization (PA) from the Department before the service is provided.

Idaho Medicaid uses nationally recognized criteria in making PA determinations. The following documentation is needed to determine the medical necessity for additional visits:

- Evaluation by the licensed therapist completed during the last year.
- Current plan of care (POC) signed and dated by the physician or mid-level, completed every 30 days for acute conditions and every six months for chronic conditions. The minimum requirements are:
    - Diagnosis.
    - Modalities.
    - Anticipated short and long-term goals that are outcome-based with measurable objectives.
    - Frequency of treatment.
    - Expected duration of treatment and discharge plan.
- Reports of current status.
- Communication and coordination with other providers. Documentation may include, dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of this provider.
- Copies of IFSP or IEP.
- Copies of daily therapy entries completed within the last 30 days.
- Number of visits being requested.

- Date range of requested services.

All PA requests should be sent to:

Medicaid Medical Care Unit
Therapy Authorizations
PO Box 83720
Boise, ID 83720-0036
(208) 364-1904
Fax: (208) 332-7280

3.3.6.4 Daily Entries

According to IDAPA 16.05.07 in section 101:

> "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:

- Date and time of service.
- Duration of the session (time in and out).
- Specific treatment provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the participant's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a scheduled session does not occur as scheduled, the provider must indicate the reason the POC was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

3.3.7 Emergency Department (ED) Limitations

Payment for ED visits, revenue code **450**, is limited to six per calendar year. Count the ED visit as one unit unless the participant is seen twice on the same day.

Emergency department visits that are followed by an immediate admission to inpatient status should be billed as part of the inpatient service and will be excluded from the six visit limit.

When total ED visits are exhausted, all other Medicaid covered charges on the claim form are still reimbursable.

3.3.8 Emergency Department Co-Payment

A Medicaid participant can be assessed a three dollar ($3) co-payment for inappropriate emergency room utilization when these three conditions are met:

- The required medical screening indicates that an emergency medical condition does not exist as determined by the emergency room physician applying the prudent layperson standard. A co-payment may not be charged if the physician determines that a prudent layperson would have sought emergency treatment in the same circumstances, even if the care rendered is for a non-emergent condition.
- The Medicaid participant is not a Native American or Alaskan Native.

- There is an alternative setting for the Medicaid participant to receive treatment at no cost. A Medicaid participant can receive no cost treatment from their Healthy Connection's primary care provider (PCP) or at an Urgent Care Clinic with a referral from their PCP. The hospital is required to facilitate a referral to an appropriate provider in order to impose a co-pay or deny treatment to a Medicaid participant who does not make a co-payment.

When a hospital determines that a co-payment can be imposed, the hospital can require the Medicaid participant make the co-payment in order to receive treatment.

Note: The collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid. However, all the conditions outlined above must be met if a hospital wishes to deny treatment to a Medicaid participant who presents in the emergency room with a non-emergent condition.

3.3.9 Healthy Connections (HC) Referral

Services performed in an ED do not require a HC referral. Services billed on an UB-04 claim form with revenue code **450** and services billed on a CMS-1500 claim form (with POS **23**) are exempt from the HC referral requirement.

3.3.10 Billing Procedures

3.3.10.1 Medicare Crossover Participants

Medicare claims will automatically cross over from Medicare to Medicaid. However, if the claim does not automatically cross over, a copy of the Medicare Remittance Notice (MRN) must be included with the claim form before submission to Medicaid. Providers can also submit electronic crossover claims using PES or other vendor software.

See *Section 2.5 Crossover Claims*, *General Billing Information,* for more information.

3.3.10.2 Third Party Recovery (TPR)

See *Section 2.4 Third Party Recovery*, *General Billing Information*, regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

3.3.10.3 Oral Surgeons

Oral Surgeons who perform services in the hospital setting are required to bill CPT surgical codes on the CMS-1500 claim form using their physician provider number. Do not use CPT procedure code 41899 (Unspecified Code), it will cause a delay in payment for services. Extractions must be billed on an American Dental Association (ADA) Claim form under the dental provider number, with the appropriate Current Dental Terminology (CDT) dental code and tooth number, quadrant, or arch designation, and prior authorization (PA) number if applicable.

3.4 Prior Authorization (PA)

3.4.1 Overview

The Idaho Medicaid Program has contracted with Qualis Health; a quality improvement organization (QIO), to conduct the medical and surgical reviews of inpatient and selected outpatient hospital services. The appropriateness and necessity of the participant's admission and length of stay are subject to QIO review.

See *Sections 3.4.12 Inpatient and Outpatient Psychiatric and Rehabilitation Diagnoses Requiring Prior Authorization (PA), and 3.4.13 Inpatient and Outpatient Procedures Requiring Quality Improvement Organization (QIO) Prior Authorization (PA)*, for a listing of the diagnosis and surgical procedure codes that require PA. Refer to the Qualis Health Provider Manual for details regarding review procedures.

The attending physician is ultimately responsible for obtaining preadmission approval (except for emergencies). However, the QIO will accept preadmission monitoring calls from the surgeon, physician office personnel, or facility personnel when applicable. HC participants require a referral from their primary care provider (PCP) for all inpatient and outpatient hospital services in addition to the QIO PA.

When billing, if PA is required, the PA number must be indicated on the claim. Enter the PA number in field **63** on the UB-04 claim form. For electronic claims, enter the PA number in the PA field on the screen. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For Healthy Connections (HC) participants, PA will be denied if the requesting provider is not the PCP or a referral has not been obtained.

3.4.2 Admitting and Principal Diagnoses

It is very important to include the admitting diagnosis code in field **69** and the principal diagnosis code in field **70** on the claim. These codes are used to determine if the admission requires QIO review.

If the admitting diagnosis and the principal diagnosis are different, and one of them is a condition that does require preadmission review, then the admission requires QIO preadmission review.

3.4.3 Length of Stay Review

Concurrent review is required when the admission exceeds day three or day four if the patient had a cesarean delivery, or the number of days assigned by the QIO for a procedure. In the event the admitting diagnosis is different from the principal diagnosis, the diagnosis that allows the greatest length of stay is used to determine the length of stay for the admission. When QIO approval has been given for a portion of the hospital stay, accommodation days are payable only to the QIO scheduled discharge date or the last approved day.

Example: If the discharge date is 08/15/2005 and QIO approved discharge is 08/14/2005, the last accommodation day to be covered by Medicaid would be 08/13/2005.

Although the room charge is not covered for 08/14/2005, the ancillary charges can be submitted with the stay. Medicaid would not pay the accommodation or ancillaries for 08/15/2005.

3.4.4 Transfers

Quality improvement organization authorization is not required for transfers from hospital to hospital inpatient status (inter-facility).

Authorization is required for transfers into psychiatric, substance abuse, or rehabilitation units within the same hospital (intra-facility). The receiving unit is responsible for obtaining the authorization within one working day of the transfer. The sending unit is not required to obtain a transfer review.

3.4.5 Out-of-State Providers

All medical care provided outside the state of Idaho is subject to the same PA and continued stay review requirements and restrictions as medical care provided within Idaho. See *Section 3.4.12 Inpatient and Outpatient Psychiatric and Rehabilitation Diagnoses Requiring Prior Authorization (PA),* and *Section*

3.4.13 Inpatient and Outpatient Procedures Requiring Quality Improvement Organization (QIO) Prior Authorization (PA), for a list of diagnoses and procedures requiring PA review. If PA is required, the PA number must be included on the claim or that service will be denied.

The participant's physician(s) or the treating facility may initiate the request for PA. The treating physician(s) and the treating facility are equally responsible for obtaining PA.

Medicaid transportation (MT) unit must PA non-emergent transportation for out-of-state care. Providers may contact MT at:

(800) 296-0509 ext. 1172 or 1173 (toll free)
Fax: (208) 334-4979 or (800) 296-0513 (toll free)

3.4.6 Admission for Substance Abuse

With implementation of OBRA 90, Medicaid coverage of substance abuse includes certain inpatient detoxification and rehabilitation services.

Quality improvement organization approval is required for inpatient services under either the psychiatric or chemical dependency admissions category (diagnosis codes **290.0 - 314.9**) or the rehabilitation admissions category (diagnosis code **V57.0 - V57.9**).

3.4.7 Cesarean Section

When billing for a cesarean section, use the appropriate diagnosis code indicating the reason for the cesarean section. The following range of diagnoses in the table below have a four day length of stay (LOS) and require a review with DHWs QIO, Qualis Health, if the patient is not discharged after the fourth day.

Contact Qualis Health toll-free at: **(800) 783-9207** for a telephonic review or fax your requests to: **(800) 826-3836**.

Diagnosis Code (Code to the 5th digit 642.5 - 663.4)	Description
642.5 (0,1,2,4**)**	Severe pre-eclampsia
652.2 - 652.8 (0,1,3)	Malposition and malpresentation of fetus
653.4 (0,1,3)	Fetopelvic disproportion.
654.2 (0,1,3)	Abnormality of organs and soft tissues of pelvis, previous cesarean delivery.
659.7 (0,1,3)	Abnormality in fetal heart rate or rhythm.
660.0 - 660.8 (0,1,3)	Obstructed labor.
661.00 - 661.43	Abnormality of forces of labor.
663.1 - 663.3 (0,1,3)	Umbilical cord around neck, with compression.
663.4 (0,1,3)	Umbilical cord complications, short cord.
763.4	Fetus or newborn affected by other complication of labor and delivery, cesarean delivery.
V30.01	Single liveborn, born in a hospital, delivered by cesarean delivery.
V31.01	Twin, mate liveborn, born in a hospital, delivered by cesarean delivery.
V32.01	Twin, mate stillborn, born in a hospital, delivered by cesarean delivery.
V33.01	Twin, unspecified, born in a hospital, delivered by cesarean delivery.
V34.01	Other multiple, mates all liveborn, born in a hospital, delivered by cesarean delivery.

Diagnosis Code (Code to the 5th digit 642.5 - 663.4)	Description
V35.01	Other multiple, mates all stillborn, born in a hospital, delivered by cesarean delivery.
V36.01	Other multiple, mates live and stillborn, born in a hospital, delivered by cesarean delivery.
V37.01	Other multiple, unspecified, born in a hospital, delivered by cesarean delivery.

3.4.8 Medicaid/Medicare Eligibility

Some Medicare participants have both Medicare and Medicaid coverage for hospitalizations. For those participants with Part A Medicare (inpatient services), QIO review is not necessary if Medicare is the primary payer. Medicare guidelines should be followed. If, however, the participant has only Part B Medicare (outpatient services), the admission is subject to QIO review because Medicaid is the primary payer for the inpatient services. For additional information regarding third party coverage or to verify eligibility, contact MAVIS at:

(208) 383-4310 in the Boise calling area
(800) 685-3757 (toll free)

The automated system is available 24 hours a day. Provider representatives are available Monday through Friday from 8 a.m. – 6 p.m. MT (excluding state holidays).

3.4.9 Other Insurance

When the participant has other insurance, QIO authorization is required, although the other insurance must be billed prior to Medicaid. Use MAVIS to verify other insurance coverage.

3.4.10 Retrospective/Late Quality Improvement Organization (QIO) Reviews

Retrospective Review: A review of cases for participants who were not eligible at the time of the admission but who were determined eligible at a later date. In these cases, Medicaid will not assess penalties to the provider.

Note: Claims must be billed within one year of the date of service.

Late Review: A review of cases where the participant was eligible and PA was not obtained prior to the hospital admission. Qualis Health accepts telephonic requests for late reviews only if the participant is still in the hospital at the time Qualis Health is notified. If the participant has already been discharged, providers must request a late review by submitting a Retrospective Review Request form to Qualis Health with a copy of the history and physical, discharge summary, completed UB-04 claim form, and operative report (if applicable). Refer to the *Qualis Health Provider Manual Exhibit 15*, for a copy of the request form and additional instructions.

Medicaid may assess a penalty if a hospital does not secure a QIO review in a timely manner. These penalties are based on how late the review is made, as follows:

One day late = $260.

Two days late = $520.

Three days late = $780.

Four days late = $1,040.

Five days late = $1,300.

Qualis Health does not have authority to reverse late review penalties. Appeals regarding penalties should be directed to:

Office of Financial Recovery
PO Box 83720
Boise, ID 83720-0036
(208) 287-1152 in the Boise calling area
Fax: (208) 334-6515 or (866) 849-3843 (toll free)

For all other QIO issues contact Idaho Medicaid at:
(208) 287-1177 in the Boise calling area
Fax: (208) 332-7280

3.4.11 Contacting Qualis Health

Qualis Health
PO Box 33400
Seattle, WA 98133-9075
To reach Qualis Health call: (800) 783-9207, press 122
Fax: (800) 826-3836

Provider representatives are available Monday through Friday from 7:30 a.m. - 6:45 p.m. MT (excluding state holidays). Voice mail is available 24-hours a day, seven-days a week. Access Qualis Health via the internet at: **http://www.qualishealth.org/cm/idaho-medicaid/overview.cfm**.

3.4.12 Inpatient and Outpatient Psychiatric and Rehabilitation Diagnoses Requiring Prior Authorization (PA)

Inpatient and outpatient procedures that require QIO PA include the following codes, when performed on Idaho Medicaid participants and children in the legal custody or legal guardianship of the state of Idaho, Division of Family and Children Services.

Note: Participants with Medicaid Basic Plan are limited to ten days of inpatient mental health services per year.

Diagnosis Codes
Inpatient psychiatric or chemical dependency admissions (use fourth or fifth digit sub-classification): **290.0** - **314.9**.
Inpatient physical rehabilitation admissions: **V57.0** - **V57.9**. **Note:** This includes admission to all rehabilitation hospitals, regardless of the diagnosis on the claim.

3.4.13 Inpatient and Outpatient Procedures Requiring Quality Improvement Organization (QIO) Prior Authorization (PA)

QIO PA is also required for all elective or scheduled admissions when the participant is admitted one or more days prior to a planned surgery that is on the select PA list.

All surgical procedures on the following list require pre-authorization for inpatient and outpatient services. For more information please call at: **(800) 783-9207** or fax at: **(800) 826-3836**.

The select PA list is also available on the Quails Web site at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm**.

Procedure	ICD-9-CM Code October 2007	CPT® Code January 2008
Arthrodesis (Spinal Fusion)	78.59 81.00 through 81.08	22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804,

Procedure	ICD-9-CM Code October 2007	CPT® Code January 2008
Note: Artificial disc not a covered benefit.	81.30 through 81.39	22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280
Unlisted neck, thorax procedure	81.62, 81.63, 81.64	21899
Unlisted spine procedure	78.41 78.71	22899
Laminectomy/Diskectomy Laminoplasty	03.02 03.09 03.1 03.6 80.50 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185,63190, 63191, 63194, 63195,63196,63197, 63198, 63199, 63200
Hysterectomy		
Abdominal	57.84, 65.61 68.31, 68.39, 68.41, 68.49, 68.61, 68.69	51925, 58956, 58180, 58953, 58954, 59135, 59525 58150, 58152, 58200, 58951, 59135, 59525
Vaginal	68.51 68.59	58210 58550, 58260, 58262, 58263, 58267, 58270, 58552, 58553, 58554 58275, 58280, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548
Laparoscopic	68.71, 68.79 68.9	58570, 58571, 58572, 58573
Radical		58285
Other and Unspecified		
Reduction Mammoplasty Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement Revision	81.51 81.53 00.70–00.76, 00.77, 00.85, 00.86, 00.87	27130 27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125

Procedure	ICD-9-CM Code October 2007	CPT® Code January 2008
Total Knee Replacement Revision	81.54 81.55 00.80–00.84	27445, 27446, 27447 27486, 27487
Transplants **Note:** Transplant facilities must be Medicare approved.)		
Bone Marrow Transplant Autologous Allogenic	 41.00, 41.01, 41.04, 41.07, 41.09 41.02, 41.03, 41.05, 41.06, 41.08	 38241 38240, 38242
Heart Transplant	37.5, 37.51, 37.52, 37.53, 37.54	33945
Intestinal Transplant	46.97	44133, 44135, 44136, 44715, 44720,44721
Kidney Transplant	55.61 55.69	50323, 50325, 50327, 50328, 50329, 50360, 50365, 50380
Liver Transplant	50.59	47135, 47136, 47143, 47144, 47145, 47146, 47147
Note: Liver from live donor not a covered benefit		
Lung Transplant **Note:** Restricted to age 0 – 21	**33.50, 33.51**	**32850, 32851, 32852, 32853, 32854, 32855, 32856** ***(effective 7/1/08)***
Combined Heart-Lung Transplant	**33.6**	
Bariatric Surgery	44.31, 44.95	43644, 43645, 43845, 43846, 43847, 43848, 43770, 43771, 43772, 43773, 43774
Note: Procedure must be performed in a Medicare approved Bariatric Surgery Center (BSC) or Bariatric Surgery Center of Excellence (BSCE)		
Panniculectomy	86.83	15830, 15847, 15877
Alcohol and Drug Rehabilitation and Detoxification **Inpatient Only**		
Alcohol Rehabilitation	94.61	90899

Procedure	ICD-9-CM Code October 2007	CPT® Code January 2008
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899
Psychiatric Admissions- **Inpatient Only**	291.0 through 314.9 (Diagnosis Codes)	
Physical Rehabilitation - **Inpatient Only** Care involving use of rehabilitation procedures	V57.0 – V57.9 (Diagnosis Codes) This includes admission to all rehabilitation facilities, regardless of diagnosis.	
Current Procedural Terminology (CPT®) is copyright American Medical Association 2008. All rights reserved. CPT is a registered trademark of the American Medical Association.		

Approved List of V-Codes That May Be Used for Principal Diagnoses

The V-Codes in the current ICD-9 CM book, Tabular List for V-Codes, listed as acceptable codes for use as a principal diagnosis will be used for pre-authorization and concurrent review purposes.

Only these V-Codes will be accepted by the Qualis Health nurse reviewers when performing pre-authorization or concurrent review for Idaho Medicaid clients.

3.4.14 Inpatient and Outpatient Prior Authorization (PA) by Medicaid

Medicaid PA is required for the following procedures:

- Reconstructive surgery not on the Qualis Health list.
- Plastic surgery not on the Qualis Health list.
- Cosmetic surgery not on the Qualis Health list.
- Elective surgery not on the Qualis Health list.
- Administratively necessary days (AND).
- Excluded services found medically necessary in an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screen.

- Physical therapy visits that exceed 25 visits, per calendar year.
- Genetic pathology and laboratory testing.

See *Section 3.4.15 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)*, for the listing of medical and surgical procedure codes that require PA from Medicaid.

Send PA requests to:

Division of Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 332-7280

Note: When billing, if a PA is required, the PA number must be included on the claim or the claim will be denied.

Healthy Connection participants require a referral from their PCP for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health PA.

3.4.15 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)

Proc	Description
03.29	Other chordotomy.
03.93	Implantation or replacement of spinal neurostimulator lead(s).
11970	Replacement of tissue expander with permanent prosthesis
17106	Destruction of cutaneous vascular proliferative lesions, less than 10 sq cm.
17107	Destruction of cutaneous vascular proliferative lesions, 10.0 - 50.0 sq cm.
17108	Destruction of cutaneous vascular proliferative lesions, over 50.0 sq cm.
19316	Mastopexy.
19324	Mammoplasty, augmentation without prosthetic implant.
19325	Mammoplasty augmentation with prosthetic implant.
19328	Removal of intact mammary implant.
19330	Removal of mammary implant material.
19340	Immediate insertion of breast prosthesis.
19342	Delayed insertion of breast prosthesis.
19350	Reconstruction, nipple/areola.
19357	Breast reconstruct with tissue expander including subsequent expansion.
19361	Breast reconstruct with latissimus dorsi flap, with or without prosthetic implant.
19364	Breast reconstruction with free flap.
19366	Breast reconstruction with other technique.
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM).
19368	Breast reconstruction (TRAM), with microvascular anastomosis.
19369	Breast reconstruction.
19370	Open periprosthetic capsulotomy, breast.

Proc	Description
19371	Periprosthetic capsulectomy, breast.
19380	Revision of reconstructed breast.
19499	Unlisted procedure, breast.
29999	Unlisted procedure, arthroscopy.
30462	Rhinoplasty; tip, septum, osteotomies.
36475	Endovenous ablation therapy of incompetent vein, extremity, radiofrequency.
36476	Endovenous ablation therapy of incompetent vein, second, and subsequent.
36478	Endovenous ablation therapy of incompetent vein, extremity, laser.
36479	Endovenous ablation therapy of incompetent vein, second, and subsequent.
37700	Ligation and division of long saphenous vein.
37718	Ligation, division, and stripping, short saphenous vein.
37722	Ligation, division, and stripping, long (greater) saphenous veins.
37735	Ligation, division, and complete stripping of long or short saphenous veins, with excision of deep fascia.
37760	Ligation of perforator veins, subfascial, radical, with or without skin graft, open.
37780	Ligation and division of short saphenous vein at saphenopopliteal junction.
37785	Ligation, division and/or excision of varicose vein cluster(s), one leg.
38.59	Leg varicose veins ligation and stripping.
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum.
43648	Revision or removal of gastric neurostimulator electrodes, antrum.
43659	Laparoscopy, unlisted stomach procedure.
43850	Revision of gastroduodenal anastomosis with reconstruction, without vagotomy.
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open.
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open.
48160	Pancreatectomy, total or subtotal, with autologous transplantation.
50.51	Auxiliary liver transplant, leaving patients own liver in situ.
52640	Transurethral resection of postoperative bladder neck contracture.
59866	Multifetal pregnancy reduction(s).
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to single electrode array.
63650	Percutaneous implantation of neurostimulator electrode array, epidural.
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural.
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s).
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct, or inductive coupling.
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver.

Proc	Description
64553	Percutaneous implantation of neurostim. electrodes; cranial nerve
64555	Percutaneous implantation of neurostim. electrodes; peripheral nerve, excl sacral
64560	Percutaneous implantation of neurostim. electrodes; autonomic nerve
64561	Percutaneous implantation of neurostim, electrodes; sacral nerve, transforaminal
64565	Percutaneous implantation of neurostimulator electrodes; neuromuscular
64573	Incision for implant of neuro electrodes, cranial nerve.
64575	Incision for implant of neurostim. electrodes, peripheral nerve, excludes sacral nerve
64577	Incision for implant of neuro electrodes, autonomic nerve.
64580	Incision for implant of neurostim.electrodes,
64581	Incision for implant of neurostim. Electrodes, sacral nerve, transforaminal placement
64585	Revision or removal of peripheral neurostim. electrodes
64590	Insertion or replacement of peripheral gastric neurostimulator pulse generator or receiver, direct or inductive coupling.
64595	Revision or removal of peripheral or gastric neurostim. pulse generator or receiver
64999	Unlisted procedure, nervous system.
69714	Implantation, osseointegrated implant, temporal bone.
69715	Implantation, osseointegrated implant, temporal bone, with mastoidectomy.
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone.
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with mastoidectomy.
69930	Cochlear device implant, with or without mastoidectomy.
85.53	Unilateral breast implant.
85.54	Bilateral breast implant.
85.70	Total reconstruction of breast, not otherwise specified.
85.71	Latissimus dorsi myocutaneous flap
85.72	Transverse rectus abdominis mycutaneous (TRAM) flap, pedicled
85.73	Transverse rectus abdominis mycutaneous (TRAM) flap, free
85.74	Deep inferior epigastric artery perforator (DIEP) flap, free
85.75	Superficial inferior epigastric artery (SIEA) flap, free
85.76	Gluteal artery perforator (GAP) flap, free
85.79	Other total reconstruction of breast
85.83	Breast full-thick graft.
85.84	Breast pedicle graft.
85.85	Breast muscle flap graft.
85.87	Nipple repair nec.

Proc	Description
85.93	Breast implant revision.
85.94	Breast implant removal.
85.95	Insert breast tissue expander.
85.96	Remove breast tissue expander.
85.99	Breast operation nec.
86.94	Insertion or replacement of single array neurostimulator pulse generator.
86.95	Insertion or replacement of dual array neurostimulator pulse generator.
86.96	Insertion or replacement of other neurostimulator pulse generator.
86.97	Insertion or replacement, single array n.s. pulse generator, rechargeable.
86.98	Insertion or replacement, dual array n.s. pulse generator, rechargeable.
87903	Phenotype analysis by DNA/RNA, HIV 1, 1 - 10 drugs tested.
87904	Phenotype analysis by DNA/RNA, HIV 1, each additional 1 - 5 drugs.
97799	Unlisted physical medicine/rehabilitation service or procedure.
99.99	Other miscellaneous procedures, other.

3.4.15.1 Positron Emission Tomography (PET) Scan

Bill PET scans with revenue code **404**, the authorized HCPCS code, and modifier **TC**.

Note: Positron emission tomography scans do not require PA from Medicaid.

3.4.16 Attachments

Inpatient attachments include the following:

- **Third party recovery (TPR):** When billing on a paper claim form, attach the Explanation of Benefits (EOB) statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate ARC codes from the other insurer, no attachment is required.
- **Hysterectomies:** Authorization for hysterectomy and documentation of medical necessity.
- **Sterilizations:** Appropriately completed consent form.

  For more information concerning sterilizations, see Information Release MA06-30 at: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3430/DesktopDefault.aspx**.
- **Therapeutic abortions:** Completed certification of necessity from physician. For more information concerning abortions, see Information Release MA02-29 at: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3430/DesktopDefault.aspx**, and the rules concerning abortion, including the certification requirements, in *IDAPA 16.03.09.511-514*, at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**.
- **Private room:** Statement of medical necessity or physician order.

Outpatient attachments include:

- **TPR:** When billing on a paper claim form, attach the EOB statement from the other insurer that includes the ARC. When billing electronically, use the appropriate ARC from the other insurer, no attachment is required.

- **Sterilization:** Appropriately completed consent form.

3.4.17 Hospital Physicians

Hospital based physician billers should refer to, *Section 3 Physicians Guidelines*, for more information on submitting a CMS-1500 claim form.

3.5 Administratively Necessary Days (AND)

3.5.1 Overview

Administratively necessary days are intended to allow a hospital the time for an orderly transfer or discharge of inpatients that are no longer in need of a continued acute level of care. Administratively necessary days may be authorized for inpatients that are awaiting placement in a skilled nursing facility (SNF), intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR), in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

3.5.2 Prior Authorization (PA)

The hospital discharge planner, utilization reviewer, or attending physician must contact the Medical Care Unit by phone or fax to request an AND. The AND Intake form must be submitted to the Medical Care Unit prior to the patient being decertified as needing acute hospital care. This can be done as soon as the discharge planner anticipates a possible discharge issue, even before the final non-certified date is known. The facility must supply the additional required documentation within ten working days of the submitted request.

Form Available: The AND Intake form is included in *Appendix D; Forms*.

If the AND is not necessary, due to a reversal of the possible non-certification, immediately notify the Medical Care Unit, at the number below, and the request will be voided. When billing the AND, the PA number must be included on the claim.

To request an AND, fax the AND Intake form and required documentation to:
(208) 332-7280

For questions, call: **(208) 364-1818**.

The following documentation is required for PA of an AND:

- AND Intake form.
- Summary of patient's medical condition.
- Current history and physical.
- Physician progress notes.
- Statement as to why patient cannot receive necessary medical services in a non-hospital setting.
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services.

3.5.3 Retroactive Eligibility

Services provided to an individual will be deemed prior approved if the individual was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible. The service provided is approved by the Department of Health and Welfare (DHW) with the same guidelines and documentation requirements as other PA requests for AND.

3.5.4 Notice of Decision

The Department of Health and Welfare will review each PA request and issue a decision and PA number, which is faxed to the requesting provider. The Department of Health and Welfare will also issue a Notice of Decision letter for each PA request, which is mailed to the participant and the requesting provider.

3.5.5 Billing Procedures

Administratively necessary day services must be billed on the UB-04 claim form as an outpatient service. The first AND should be the same day the participant was discharged from the inpatient acute level of care. The AND authorization number must be in PA field **63** of the claim form.

The hospital should utilize the same billing procedure as is currently used for outpatient claims with the following exceptions when billing for an AND:

- Type of Bill (field **4**) use code **151**.
- Revenue Codes (field **42**).
- Supplies and ancillary charges (except those listed in *Section 3.5.6 Revenue Codes*), are part of the content of care.

3.5.6 Revenue Codes

Listed below are the only revenue codes that can be billed with an AND.

CPT Must list valid CPT laboratory procedure code.

QIO Authorization must be attached.

HOSP The ambulance must be owned and operated by the hospital.

HCPCS Must list valid HCPCS code.

280 Oncology general
289 Oncology other
300 Laboratory CPT
301 Chemistry CPT
302 Immunology CPT
303 Renal participant (home) CPT
304 Non-routine dialysis CPT
305 Hematology CPT
306 Bacteriology/Microbiology CPT
307 Urology CPT
310 Lab pathology
311 Cytology
312 Histology
314 Biopsy
320 Radiology, diagnostics CPT
321 Angiocardiography CPT
322 Arthrography CPT
323 Arteriography CPT
324 Chest x-ray CPT
330 Radiology therapy
331 Chemotherapy injected
332 Chemotherapy oral
333 Radiation therapy
335 Chemotherapy IV
340 Nuclear medicine CPT
341 Diagnostic CPT
342 Therapeutic, oral
350 Computed axial tomography (CAT) scan CPT
470 Audiology
471 Diagnostic
472 Treatment
480 Cardiology
481 Cardiac catheterization lab
482 Stress test
489 Other cardiology
540 Ground ambulance (hospital based), non-emergency
541 Ambulance supplies
542 Ground ambulance, emergency
544 Ambulance oxygen
545 Air ambulance, all levels of life support
546 Ground or air ambulance, neonatal services
547 Ambulance pharmacy
548 Ambulance electrocardiogram (EKG) services
610 Magnetic resonance imaging (MRI), trunk and extensions CPT
611 MR I, brain and brainstem CPT
612 MRI, spine and spinal cord CPT
671 Outpatient special residence charges, hospital based, AND
730 EKG/ECG
731 Holter monitor
732 Telemetry (including fetal monitor)
740 electroencephalogram (EEG)
750 Gastro-Intestinal
790 Lithotripsy
811 Living donor, kidney QIO
812 Cadaver donor, kidney QIO
813 Unknown donor, kidney QIO

351 Head scan [CPT]
352 Body scan [CPT]
380 Blood services
381 Packed red cells
382 Whole blood cells
383 Plasma
384 Platelet
385 Leukocytes
386 Other components
387 Other derivatives (cryopricipitates)
390 Blood storage and processing
391 Blood administration
400 Other imaging services [CPT]
401 Diagnostic mammography [CPT]
402 Ultrasound [CPT]
403 Screening mammography [CPT]
404 Positron emission tomography (PET) [HCPCS]

410 Respiratory services
460 Pulmonary function

819 Other organ acquisition [QIO]
820 Hemodialysis, outpatient or home
821 Hemodialysis/Composite or other rate [CPT]
830 Peritoneal dialysis
831 Peritoneal composite [CPT]
840 CAPD, outpatient or home
841 CAPD composite or other rate [CPT]
850 CCPD outpatient or home
851 CCPD composite or other rate [CPT]
880 Miscellaneous dialysis
881 Ultrafiltration
889 Other miscellaneous dialysis
921 Peripheral vascular lab
922 Electromyography (EMG)
923 Pap smear
924 Allergy test [CPT]
925 Pregnancy test

946 Air fluidized bed
947 Other therapeutic complex medical equipment

3.6 Coverage Limits

3.6.1 Excluded Services

Services excluded from Medicaid coverage include the following:

- Acupuncture services.
- Biofeedback therapy.
- Laetrile therapy.
- Eye exercise therapy.
- Surgical procedures on the cornea for myopia.
- Cosmetic surgery, excluding reconstructive surgery, which has prior approval by the Department of Health and Welfare (DHW).
- Elective medical and/or surgical treatment, except for family planning services, without DHW prior authorization (PA).
- Vitamin injections in the doctor's or other licensed prescriber's office that are not needed for a specific diagnosis.
- Organ transplants; lung, pancreas, multiple organ, or other transplant considered investigative or experimental.
- New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service. If these procedures are excluded by the Medicare program, they are also excluded from Medicaid payment.
- Treatment of complications, consequences, or repair of any medical procedure, in which the original procedure was excluded from Medicaid coverage, unless the resultant condition is deemed life threatening as determined by Medicaid.
- Examinations in connection with the attendance, participation, enrollment, or accomplishment of a program or for employment.
- Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial insemination, consultations, counseling, office exams, tuboplasties, and vasovasotomies.
- Naturopathic services.
- Abortions except when the mother's life is in jeopardy or in cases of rape or incest.

3.6.2 Restricted Procedures

3.6.2.1 Physical Therapy

Outpatient physical therapy or occupational therapy visits that exceed 25 visits per calendar year and speech-language pathology services that exceed 40 visits per calendar year require PA from the Medical Care Unit. See *Section 3.3.6 Outpatient Therapy Limitations*, for additional information.

3.6.2.2 Cosmetic Surgery

All cosmetic surgery must be medically necessary and have a Medicaid PA.

3.6.2.3 Obesity

Bariatric Surgery: Medicaid will only cover bariatric surgeries, including abdominoplasty and panniculectomy, when all of the following conditions are met:

- The participant meets the criteria for morbid obesity as defined in, *IDAPA 16.03.09.431 Surgical Procedures for Weight Loss – Participant Eligibility* through *434 Surgical Procedures for Weight Loss – Provider Qualifications and Duties.*
- The procedure is prior authorized by Qualis Health. If approval is granted, Qualis Health will issue the authorization number and conduct a length-of-stay review.
- The procedure(s) must be performed in a Medicare-approved bariatric surgery center (BSC) or bariatric surgery center of excellence (BSCE).
- Medicaid has given final approval for the procedure(s).

For more information about the criteria for bariatric surgery; see *Section 3.2.5.2 Bariatric Surgery, Physician Guidelines.*

3.6.2.4 Transplants

The Department of Health and Welfare (DHW) may purchase organ transplant services for bone marrow, kidneys, hearts, intestines, and livers when provided by hospitals approved by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program. The hospital must have completed a provider agreement with DHW.

The Department of Health and Welfare may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. Transplants, except for cornea transplants, must be prior authorized by the quality improvement organization (QIO).

Hospitals should obtain and use a separate provider number issued by Idaho Medicaid for transplants. This allows the hospital to accurately receive the lesser of 96.5 percent of reasonable costs under Medicare's payment principals or customary charges.

The transplant costs for actual or potential living donors are covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Donor costs for transplants should be billed using the participant's name and Medicaid identification (MID) number. Enter *Donor Charges* in the remarks field of the claim form to prevent a denial of the claim as a duplicate.

Payments for post-operation expenses of a donor will be limited to the period of actual recovery.

Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to independent organ procurement agencies and independent histocompatibility laboratories will not be covered.

Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts are not covered.

See *IDAPA 16.03.10.090 Organ Transplants through 096 Organ Transplants - Provider Reimbursements*, for additional information.

3.6.2.5 Fertility

Procedures or testing for the inducement of fertility are not a benefit of the Medicaid program. This includes, but is not limited to:

- Artificial insemination.
- Consultations.
- Counseling.
- Office exams.
- Tuboplasties.
- Vasovasotomies.

3.6.2.6 Take Home Drugs

Outpatient take home drug charges that exceed $4.00 must be billed on the Idaho Medicaid Pharmacy claim form. Inpatient take home drugs dispensed upon discharge must also be submitted on the Pharmacy claim form. All outpatient take home drugs must have the National Drug Code (NDC) identified on the claim.

3.6.2.7 Examinations

Examinations for the following are not payable:

- Routine examinations, other than those associated with the EPSDT Program.
- Routine examinations, other than the periodic health risk assessment.
- Examinations related to attendance, participation, enrollment, or accomplishment of a program.
- Examinations related to employment.
- Premarital examination.

3.6.2.8 Inpatient Mental Health

Inpatient mental health services are limited to ten days per year for participants who are eligible under the Medicaid Basic Plan.

3.6.3 Exceptions

Some excluded services/procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during an EPSDT screen. Such excluded services/procedures must be prior authorized by Medicaid.

Some examples of the services for which payment may be made are private duty nursing in the participant's home and outpatient substance abuse treatment. Any service recognized under the provisions of the Social Security Act can be made available if the above conditions are met.

3.6.4 Mammography Services

Idaho Medicaid will cover screening or diagnostic mammography performed with mammography equipment and staff that is considered certifiable or certified by the Bureau of Laboratories.

- Screening mammography will be limited to one per calendar year, for women who are 40 or more years of age.
- Diagnostic mammography will be covered when a physician orders the procedure for a patient, of any age, who is at high risk.

3.6.5 Freestanding Dialysis Units

Outpatient dialysis procedures provided by a freestanding dialysis facility should be billed on a UB-04 claim form in the following manner:

Report with bill type **721** through **724**. See *Section 3.1.4 Type of Bill Codes*, for more information.

- Medicare crossover claims (Medicare is primary insurance) cannot be sent electronically to Idaho Medicaid from Medicare and therefore, must be submitted to Idaho Medicaid with the MRN from Medicare attached.
- Dialysis procedures are reported with the following revenue codes:

821 Outpatient dialysis, CPT code **90999** (hemodialysis composite or other rate).

270 Dialysis supplies (medical surgical supplies).

272 Special supplies (sterile supplies).

634 Epoetin up to 10,000 units. (One billing unit = 1000 Units.) [CPT]

635 Epoetin over 10,000 units. (One billing unit = 1000 Units.) CPT

636 Dialysis drugs CPT (drugs requiring detailed coding), use the appropriate corresponding J-code from the most current *HCPCS Level II Manual* and attach the NDC detail attachment with the claim form (see Medicaid Information Release MA03-69).

831 Peritoneal composite rate, **90945** or **90947** CPT.

841 CAPD composite or other rate, **90945/90947** or **90993** CPT.

851 CCPD composite or other rate; **90945/90947** or **90993** CPT.

CPT Must indicate a valid CPT procedure code when billing outpatient claims.

Note: When billing using a date span, make sure the header date span is reflected in the detail dates. You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.

When the dates of service are not consecutive, each date of service must be billed on a separate detail line.

3.7 Revenue Codes

3.7.1 Overview

All hospital services must be billed using the following unique, 3-digit revenue codes. EDS will deny any claim with any other revenue codes entered.

3.7.2 Accommodation Revenue Codes

PO These revenue codes must have a signed physician's order attached to the claim form.

Rev Code	Service	Description	Patient Status
100	All inclusive room-board plus ancillary and swing bed	Not covered. Except in hospitals approved for swing bed status.	
101	All inclusive room-board		In
110	Private[PO]	Covered with medically necessary documentation.	In
111	Medical/Surgical/Gyn[PO]		In
112	Obstetric (OB)[PO]	When using this revenue code for birthing room accommodation, make sure the facility has an accommodation rate on file and specify *Birthing Room* in the Remarks field (field **80**) of the UB-04 claim form.	In
113	Pediatric[PO]		In
114	Psychiatric[PO]		In
115	Hospice	Must be billed using hospice provider number.	
116	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
117	Oncology[PO]		In
118	Rehabilitation[PO]		In
119	Other	Not covered.	
120	Room and board, semiprivate		In
121	Medical/Surgical/Gyn		In
122	OB		In
123	Pediatric		In
124	Psychiatric		In
125	Hospice	Not covered.	
126	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
127	Oncology		In
128	Rehabilitation		In
129	Other	Not covered.	
130	Semiprivate, 3 and 4 beds		In
131	Medical/Surgical/Gyn		In
132	OB		In
133	Pediatric		In
134	Psychiatric		In
135	Hospice	Not covered.	

Rev Code	Service	Description	Patient Status
136	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
137	Oncology		In
138	Rehabilitation		In
139	Other	Not covered.	
140	Private (luxury)[PO]		In
141	Medical/Surgical/Gyn (luxury)[PO]		In
142	OB (luxury)[PO]		In
143	Pediatric (luxury)[PO]		In
144	Psychiatric (luxury)[PO]		In
145	Hospice	Not covered.	
146	Detoxification (luxury)[PO]	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
147	Oncology (luxury)[PO]		In
148	Rehabilitation (luxury)[PO]		In
149	Other	Not covered.	
150	Room and board, ward		In
151	Medical/Surgical/Gyn		In
152	OB		In
153	Pediatric		In
154	Psychiatric		In
155	Hospice	Not covered.	
156	Detoxification[PO]	Medicaid will reimburse for acute level of care medical conditions only. The physician's order must be attached.	In
157	Oncology		In
158	Rehabilitation		In
159	Other	Not covered.	
160	Other room and board	Not covered.	
164	Room and board, sterile environment[PO]		In
167	Self care	Not covered.	
169	Other	Not covered.	
170	Nursery		In
171	Newborn - level 1		In
172	Premature - level II		In
173	Newborn - level III		In
174	Newborn - level IV, Neonatal Intensive Care Unit (NICU)		In
179	Other, nursery	Not covered.	
180	LOA	Not covered.	

Rev Code	Service	Description	Patient Status
181	Reserved	Not covered.	
182	Participant convenience	Not covered.	
183	Therapeutic leave	Not covered.	
189	Other leave of absence	Not covered.	
200	Intensive Care Unit (ICU)		In
201	Surgical		In
202	Medical		In
203	Pediatrics		In
204	Psychiatric		In
206	Post ICU	Not covered.	
207	Burn care		In
208	Trauma		In
209	Other intensive care	Not covered.	
210	Coronary Care Unit (CCU)		In
211	Myocardial infarction		In
212	Pulmonary care		In
213	Heart transplant		In
214	Post CCU	Not covered.	
219	Other coronary care	Not covered.	

3.7.3 Ancillary Revenue Codes

CPT Must indicate a valid CPT procedure code when billing outpatient claims.

HCPCS Must indicate a valid HCPCS procedure code when billing outpatient claims.

Rev Code	Service	Description	Patient Status
220	Special charges	Not covered.	
221	Admission charge	Not covered.	
222	Technical support charge	Not covered.	
223	UR service charge	Not covered.	
224	Late discharge, medically necessary	Not covered.	
229	Other special charges	Not covered.	
230	Incremental nursing charge		In
231	Nursery		In
232	OB		In
233	ICU		In
234	CCU		In
235	Hospice	Must bill using hospice provider number.	
239	Other	Not covered.	
240	All inclusive ancillary	Not covered.	
249	Other inclusive ancillary	Not covered.	
250	Pharmacy		In/Out

Rev Code	Service	Description	Patient Status
251	Generic drugs		In/Out
252	Nongeneric drugs		In/Out
253	Take home drugs	Must be under $4. Do not reduce charge to $4 and bill as an outpatient service. Bill correct amount on the Pharmacy claim form if amount exceeds $4.	Out
254	Drugs incident to other diagnostic services	Not covered.	
255	Drugs incident to radiology		In/Out
256	Experimental drugs	Not covered.	
257	Non-prescription		In/Out
258	IV solutions		In/Out
259	Other pharmacy	Not covered.	
260	IV therapy		In/Out
261	Infusion pump		In/Out
262	IV therapy pharmacy services		In/Out
263	IV Therapy/Drug/ Supply delivery		In/Out
264	IV Therapy/Supplies		In/Out
269	Other IV therapy	Not covered.	
270	Medical/Surgical supplies and devices	Extraordinary volume on TPN with prior approval only.	In/Out
271	Nonsterile supply		In/Out
272	Sterile supply		In/Out
273	Take home supplies	Not covered.	
274	Prosthetic/Orthotic devices	Medicaid pays for permanent or temporary medical prosthetics to reinforce or replace a biological part implanted through surgery. Devices must be prescribed by the physician. Devices without Federal Drug Administration (FDA) approval are not covered. Document specific device information in the remarks field (field **80**) of the UB-04 claim form. See *Ambulatory Surgical Center Guidelines Section 3.1.4 Payment*, for more specific information.	In/Out
275	Pacemaker		In/Out
276	Intraocular lens		In/Out
277	Oxygen, take home	Not covered.	
278	Other implant	Document in the remarks field (field **80**) of the UB-04 claim form the specific device or implant used. See *Ambulatory Surgical Center Guidelines Section 3.1.4 Payment*, for more specific information.	In/Out
279	Other devices	Not covered.	
280	Oncology general		In/Out

Rev Code	Service	Description	Patient Status
289	Oncology other		In/Out
290	Durable medical equipment DME (other than rental)	Not covered.	
291	Rental		Out
292	Purchase of new DME	Not covered.	
293	Purchase of used DME	Not covered.	
294	Supplies/Drugs for DME	Not covered.	
299	Other equipment	Not covered.	
300	Laboratory CPT		In/Out
301	Chemistry CPT		In/Out
302	Immunology CPT		In/Out
303	Renal patient (home) CPT		
304	Non-routine dialysis CPT		In/Out
305	Hematology CPT		In/Out
306	Bacteriology and microbiology CPT		In/Out
307	Urology CPT		In/Out
309	Other laboratory	Not covered.	
310	Laboratory pathological		In/Out
311	Cytology		In/Out
312	Histology		In/Out
314	Biopsy		In/Out
319	Other	Not covered.	
320	Radiology diagnostic CPT		In/Out
321	Angiocardiography CPT		In/Out
322	Arthrography CPT		In/Out
323	Arteriography CPT		In/Out
324	Chest x-ray CPT		In/Out
329	Other	Not covered.	
330	Radiology therapeutic		In/Out
331	Chemotherapy, injected		In/Out
332	Chemotherapy, oral		In/Out
333	Radiation therapy		In/Out
335	Chemotherapy - IV		In/Out
339	Other	Not covered.	
340	Nuclear medicine CPT		In/Out
341	Diagnostic CPT		In/Out
342	Therapeutic		In/Out
343	Diagnostic radiopharmaceuticals	Not covered.	
344	Therapeutic	Not covered.	

Rev Code	Service	Description	Patient Status
349	Other	Not covered.	
350	CT scan CPT		In/Out
351	Head scan CPT		In/Out
352	Body scan CPT		In/Out
359	Other Computed tomography (CT) scans	Not covered.	
360	Operating room services CPT		In/Out
361	Minor surgery CPT		In/Out
362	Organ transplant, other than kidney		In/Out
367	Kidney transplant		In/Out
369	Other OR services	Not covered.	
370	Anesthesia		In/Out
371	Anesthesia incident to radiology		In/Out
372	Anesthesia incident to other diagnostic services		In/Out
374	Acupuncture	Not covered.	
379	Other anesthesia	Not covered.	
380	Blood		In/Out
381	Packed red cells		In/Out
382	Whole blood		In/Out
383	Plasma		In/Out
384	Platelets		In/Out
385	Leukocytes		In/Out
386	Other components		In/Out
387	Other derivatives (cryopricipitates)		In/Out
389	Other blood	Not covered.	
390	Blood storage and processing		In/Out
391	Blood administration	(*e.g.* transfusions).	In/Out
399	Other blood storage/ Processing	Not covered.	
400	Other imaging service CPT		In/Out
401	Diagnostic mammography CPT	Must be physician ordered.	In/Out
402	Ultrasound CPT		In/Out
403	Screening mammography CPT	Physician's order is not required. Participant must be age 40 or older.	In/Out
404	Position emission tomography (PET) HCPCS	Must report appropriate HCPCS code. See Information Release 2003-72.	In/Out
409	Other imaging service	Not covered.	
410	Respiratory services		In/Out

Rev Code	Service	Description	Patient Status
412	Inhalation services		In/Out
413	Hyperbaric oxygen therapy		In/Out
419	Other respiratory service	Not covered.	
420	Physical therapy (PT)	Outpatient limitation: Only 25 visits per calendar year are allowed, regardless of provider.	In/Out
421	Visit charge	Not covered.	
422	Hourly charge	Not covered.	
423	Group rate	Not covered.	
424	Evaluation or re-evaluation		In/Out
429	Other PT	Not covered.	
430	Occupational therapy (OT)	Outpatient limitation: Only 25 visits per calendar year are allowed, regardless of provider.	In/Out
431	Visit charge	Not covered.	
432	Hourly charge	Not covered.	
433	Group rate	Not covered.	
434	Evaluation or re-evaluation OT		In/Out
439	Other OT	Not covered.	
440	Speech/ Language Pathology	Outpatient limitation: Only 40 visits per calendar year are allowed, regardless of provider.	In/Out
441	Visit charge	Not covered.	
442	Hourly charge	Not covered.	
443	Group rate	Not covered.	
444	Evaluation or re-evaluation Speech/Language		In/Out
449	Other Speech/Language pathology	Not covered.	
450	Emergency room		In/Out
459	Other emergency room	Not covered.	
460	Pulmonary function		In/Out
469	Other pulmonary function	Not covered.	
470	Audiology		In/Out
471	Diagnostic		In/Out
472	Treatment		In/Out
479	Other audiology	Not covered.	
480	Cardiology		In/Out

Rev Code	Service	Description	Patient Status
481	Cardiac catheter lab		In/Out
482	Stress test		In/Out
483	Echocardiology		In/Out
489	Other cardiology		In/Out
490	Ambulatory surgical care	Must report appropriate CPT or HCPCS when applicable.	Out
499	Other Ambulatory surgical centers (ASC) Care	Not covered.	
500	Outpatient services		Out
509	Other, outpatient services	Not covered.	
510	Clinic	Not covered.	
511	Chronic pain center	Not covered.	
512	Dental clinic	Not covered.	
513	Psychiatric clinic	Not covered.	
514	Obstetrician and gynecologist (OB-GYN) clinic	Not covered.	
515	Pediatric clinic	Not covered.	
519	Other clinic	Not covered.	
520	Free standing clinic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
521	Rural health, clinic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
522	Rural health, home	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
523	Family practice clinic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
529	Other free standing clinic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
530	Osteopathic services	Not covered.	
531	Osteopathic therapy	Not covered.	
539	Other osteopathic service	Not covered.	
540	Ambulance: Ground ambulance, non-emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review Authorization.	Out
541	Ambulance supplies		Out
542	Medical transport: Ground ambulance emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review Authorization.	Out
543	Heart mobile	Not Covered.	
544	Ambulance oxygen	Includes oxygen-related equipment.	Out
545	Air ambulance: All levels of life support		Out

Rev Code	Service	Description	Patient Status
546	Neonatal ambulance services: Ground or air ambulance		Out
547	Ambulance pharmacy		Out
548	Ambulance EKG services	Telephone transmission electrocardiogram (EKG).	Out
549	Other ambulance	Respond and evaluate.	Out
550	Skilled nursing (S9123) HCPCS Requires modifier **U5**	HCPCS code must be indicated in field **44** on the UB-04 claim form. Restricted to pregnant women only. Not to exceed 2 visits per pregnancy. Also used to bill home health services. Must bill using home health provider number.	In/Out
551	Skilled nursing visit	Must bill using home health provider number.	
552	Hourly charge	Not covered.	
560	Medical social services		In
561	Individual and family social services (S9127) HCPCS Requires modifier **U5**	HCPCS code must be indicated in field **44** on the UB-04 claim form. Restricted to pregnant women only. Not to exceed 2 visits.	Out
562	Hourly charge	Not covered.	
569	Risk reduction follow-up (G9005) HCPCS	HCPCS code must be indicated in field **44** on the UB-04 claim form. Restricted to pregnant women only.	Out
570	Home health aide	Not covered.	
571	Home health visit charge	Home health claims are billed on a UB-04 claim form.	Out
572	Hourly charge	Not covered.	
579	Other home health aide	Not covered.	
580	Other visits, home health	Not covered.	
581	Visit charge	Not covered.	
582	Hourly charge	Not covered.	
589	Other home health visits	Not covered.	
590	Units of service , home health	Not covered.	
599	Home health, other units	Not covered.	
600	Oxygen, home health	Not covered.	
601	Oxygen, equipment, supply, Cont.	Not covered.	
602	Oxygen, state, equipment, supply, under 1 LPM	Not covered.	
603	Oxygen, state, equipment, over 4 LPM	Not covered.	
604	Oxygen, portable add-on	Not covered.	
610	Magnetic resonance tomography (MRT) CPT		In/Out

Rev Code	Service	Description	Patient Status
611	Magnetic resonance imaging (MRI), brain and brainstem CPT		In/Out
612	MRI, spine and spinal cord CPT		In/Out
614	MRI, other CPT		In/Out
615	Magnetic resonance angiogram (MRA), head and neck CPT		In/Out
616	MRA, lower extremities CPT		In/Out
618	MRA, other CPT		In/Out
619	Other MRT	Not covered.	
621	Supplies incident to radiology		In/Out
622	Supplies incident to other diagnostic services		In/Out
623	Surgical dressings		In/Out
630	Drug home IV solution	Not covered.	
631	Single source	Not covered.	
632	Multiple source	Not covered.	
633	Restrictive prescription	Not covered.	
634	EPO < 10000 units CPT	Less than 10,000 units.	Out
635	EPO > 10000 units CPT	More than 10,000 units.	Out
636	Drugs requiring detailed coding CPT		Out
640	IV Therapy services	Not covered.	
641	Non-routine nursing, central line	Not covered.	
642	IV site care, central line.	Not covered.	
643	IV Start/Change, peripheral line	Not covered.	
644	Non-routine nursing, peripheral line	Not covered.	
645	Training participant/caregiver, central line	Not covered.	
646	Training disabled participant, central line	Not covered.	
647	Training participant caregiver, peripheral line	Not covered.	
648	Training disabled participant, peripheral line	Not covered.	
649	Other IV therapy services	Not covered.	
650	Hospice services	Must bill using hospice provider number.	
651	Routine home care	Must bill using hospice provider number.	
652	Continuous home care	Must bill using hospice provider number.	

Rev Code	Service	Description	Patient Status
655	Inpatient respite care	Must bill using hospice provider number.	
656	General inpatient care	Must bill using hospice provider number.	
657	Physician services CPT	Must bill using hospice provider number.	
659	Other hospice	Must bill using hospice provider number.	
660	Respite care/HHA	Not covered.	
661	Hourly charge/Skilled nursing	Not covered.	
662	Hourly charge/Home health	Not covered.	
671	Outpatient special residence charges, hospital based administratively necessary day (AND)		Out
700	Cast room		In/Out
709	Other cast room	Not covered.	
710	Recovery room		In/Out
719	Other recovery room	Not covered.	
720	Labor room/Delivery		In/Out
721	Labor		In/Out
722	Delivery		In/Out
723	Circumcision		In/Out
724	Birthing center	Charge must reflect a service area not an accommodation (inpatient bed, etc.).	In/Out
729	Other labor/Delivery	Not covered.	
730	EKG/ECG		In/Out
731	Holter monitor		In/Out
732	Telemetry (including fetal monitor)		In/Out
739	Other EKG/ECG	Not covered.	
740	Electroencephalogram (EEG)		In/Out
749	Other EEG	Not covered.	
750	Gastro-intestinal services		In/Out
759	Other gastro-intestinal	Not covered.	
760	Treatment/Observation room		In/Out
761	Treatment room		In/Out
762	Observation room		In/Out
769	Other treatment room	Not covered.	
771	Vaccine administration CPT		Out
790	Lithotripsy		In/Out
799	Other lithotripsy	Not covered.	
800	Inpatient renal dialysis		In

Rev Code	Service	Description	Patient Status
801	Inpatient hemodialysis		In
802	Inpatient peritoneal (non-CAPD)		In
803	Inpatient CAPD		In
804	Inpatient CCPD		In
809	Other inpatient dialysis	Not covered.	
810	Organ acquisition		In/Out
811	Living donor	A liver transplant from a live donor is not covered by Medicaid.	In/Out
812	Cadaver donor		In/Out
813	Unknown donor		In/Out
814	Unsuccessful organ search, donor bank charges	Used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.	In/Out
815	Cadaver donor		In/Out
816	Other heart acquisition		In/Out
817	Donor, liver	A liver transplant from a live donor is not covered by Medicaid.	In/Out
819	Other organ acquisition		In/Out
820	Hemodialysis outpatient or home		Out
821	Hemodialysis/Composite or other rate [CPT]		Out
822	Home supplies	Not covered.	
823	Home equipment	Not covered.	
824	Maintenance 100 percent	Not covered.	
825	Support services	Not covered.	
829	Other outpatient hemodialysis	Not covered.	
830	Peritoneal dialysis, outpatient or home		Out
831	Peritoneal/Composite [CPT] or other rate		Out
832	Home supplies	Not covered.	
833	Home equipment	Not covered.	
834	Maintenance 100 percent	Not covered.	
835	Support services	Not covered.	
839	Other outpatient peritoneal	Not covered.	
840	CAPD outpatient or home		Out
841	CAPD composite or other rate [CPT]		Out
842	Home supplies	Not covered.	
843	Home equipment	Not covered.	
844	Maintenance 100 percent	Not covered.	

Rev Code	Service	Description	Patient Status
845	Support services	Not covered.	
849	Other outpatient CAPD	Not covered.	
850	CCPD outpatient or home		Out
851	CCPD/Composite or other rate [CPT]		Out
852	Home supplies	Not covered.	
853	Home equipment	Not covered.	
854	Maintenance 100 percent	Not covered.	
855	Support services	Not covered.	
859	Other outpatient CCPD	Not covered.	
880	Miscellaneous dialysis		In/Out
881	Ultrafiltration		In/Out
882	Home dialysis aid visit	Not covered.	
889	Other miscellaneous dialysis		In/Out
890	Other donor bank		In/Out
891	Bone		In/Out
892	Organ other than kidney, liver, and heart		In/Out
893	Skin	Not payable if for cosmetic surgery.	In/Out
899	Other donor bank	Not covered.	
900	Psychiatric/Psychological treatments	Not covered.	
901	Electroshock treatment		In/Out
902	Milieu therapy	Not covered.	
903	Play therapy	Not covered.	
904	Activity therapy	Not covered.	
909	Other	Not covered.	
910	Psychiatric services	Not covered.	
911	Rehabilitation	Not covered.	
912	Partial hospitalization, less intensive	Not covered.	
913	Partial hospitalization, intensive	Not covered.	
914	Individual psychiatric therapy		In/Out
915	Group psychiatric therapy		In/Out
916	Family psychiatric therapy		In/Out
917	Bio feedback	Not covered.	
918	Testing psychiatric services		In/Out
919	Other	Not covered.	
920	Other diagnostic services	Document specific diagnostic services rendered.	In/Out

Rev Code	Service	Description	Patient Status
921	Peripheral vascular lab		In/Out
922	Electromyogram (EMG)		In/Out
923	Pap smear		In/Out
924	Allergy test CPT/HCPCS		In/Out
925	Pregnancy test		In/Out
929	Other diagnostic services	Not covered.	
940	Other therapeutic services	Document specific therapeutic services rendered.	In/Out
941	Recreational therapy		In
942	Education/Training HCPCS	For diabetes education and training, use HCPCS **G0108** (Individual Counseling) and **G0109** (Group Counseling). For pregnant women (PW) or Early Periodic Screening Diagnosis and Treatment (EPSDT) nutritional services use **S9470**. See *Section 3.10 Diabetes Education and Training,* or *Section 3.11 Dietician Service Policy,* for more information.	Out
943	Cardiac rehabilitation	Only payable within 6 weeks of heart surgery. Indicate the date of surgery and document specific cardiac rehabilitation services rendered.	In/Out
944	Drug rehabilitation		In/Out
945	Alcohol rehabilitation		In/Out
946	Complex medical equipment, routine	e.g., Air fluidized support bed.	In/Out
947	Complex medical equipment, ancillary		In/Out
949	Other therapeutic service	Not covered.	
960	Professional fees	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
961	Psychiatric	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
962	Ophthalmology	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
963	Anesthesiologist (Medical doctor)	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
964	Anesthetist (Certified Registered Nurse Anesthetist - CRNA)	Must bill on a CMS-1500 claim form using the CRNA's provider number, unless there is a Medicare exception to bill using the UB-04 claim form.	In/Out
969	Other professional fees	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
971	Laboratory	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
972	Radiology diagnostic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
973	Radiology, therapeutic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	

Rev Code	Service	Description	Patient Status
974	Radiology, nuclear medicine	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
975	Operating room	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
976	Respiratory therapy	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
977	PT	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
978	OT	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
979	Speech pathology	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
981	Emergency department	Service not covered on this claim type. Must bill on a CMS-1500) claim form.	
982	Outpatient services	Service not covered on this claim type. Must bill on a CMS-1500) claim form.	
983	Clinic	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
984	Medical social services	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
985	EKG	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
986	EEG	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
987	Hospital visit	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
988	Consultation	Service not covered on this claim type. Must bill on a CMS-1500 claim form.	
989	Private duty nurse	Not covered.	
990	Patient convenience items	Not covered.	
991	Cafeteria/Guest tray	Not covered.	
992	Private linen service	Not covered.	
993	Telephone/Telegraph	Not covered.	
994	TV/Radio	Not covered.	
995	Non-patient room rentals	Not covered.	
996	Late discharge rate	Not covered.	
997	Admission kit		In
998	Beauty/Barber shop	Not covered.	
999	Other participant convenience	Not covered.	

3.8 Ambulatory Surgical Procedures/Current Procedural Terminology (CPT) Codes

3.8.1 Ambulatory Surgical Care

Medicaid allows interim payments for specific outpatient surgical procedures using the Medicaid fee schedule for ambulatory surgical centers (ASC). This section will be updated periodically with revisions appearing in the newsletters from EDS. The CPT codes listed for the ASC procedures must match the CPT codes used by the primary physician's billing.

ASC procedures should be submitted with type of bill **831** using revenue code **490** with the appropriate 5-digit CPT code in the corresponding procedure code field. Revenue code **490** (Ambulatory Surgical Care) is used to represent operating room charges. Each claim must identify the charges for each ancillary service by the revenue code that describes the service.

Example: Charges for **490** (Operating Room), **710** (Recovery Room), **270 - 272** (Medical Supplies), **370 - 372** (Anesthesia), or **250 - 253**, **255** (Drugs) would be listed in the charge column.

3.8.2 Multiple Procedures

Multiple ASC procedures must be listed separately with a CPT code for each procedure. It is not necessary to break out the operating room charges for each line that a procedure is billed under revenue code **490**. The hospital may list all ASC procedures with only one total charge per revenue code. Any ASC procedure code billed with revenue code **490** may display the total operating room charges. Each of the other lines billing operating room revenue code **490** with an ASC procedure code may have a total charge of zero entered. Other ancillary services, *Included In*, the procedure(s) must be billed with the related total customary charges on each line. Ancillary charges must not be bundled into revenue code **490**.

Payment for multiple ASC procedures will be made at 100 percent of the price on file for the highest fee according to Medicaid's fee for service schedule. Subsequent procedures will be paid at 50 percent of the fee schedule.

3.8.2.1 Non- Ambulatory Surgical Center (ASC) Procedures

Procedures not included in Medicaid's list of ASC procedures should be billed with type of bill **131** and revenue code **360** or **361**.

Claims with multiple procedures that have at least one procedure not on the ASC list become outpatient claims payable at the outpatient reimbursement rate on file for that particular hospital. This does not include office procedures.

If an ASC procedure and a non-ASC procedure are performed at the same time, report all procedures, including the ASC procedure, on bill type **131** with revenue code **360** or **361**.

3.8.3 Included In with Bill Type 831

Certain revenue codes are considered to be included in the global fee for the procedure when billed with type of bill **831** and will not be paid separately. The following revenue codes will be denied as *Included In* the global fee.

230	**260**	**370**	**386**	**552**	**760**
239	**261**	**371**	**387**	**622**	**761**
250	**262**	**372**	**390**	**700**	**762**
251	**263**	**380**	**391**	**710**	**920**
252	**264**	**381**	**450**	**720**	
253	**270**	**382**	**500**	**721**	
255	**271**	**383**	**510**	**722**	
257	**272**	**384**	**519**	**723**	
258	**276**	**385**	**550**	**750**	

Charges for revenue codes that are not considered part of the global fee should be billed on a separate claim with type of bill **131**. Include justification on the claim or in the narrative field on claim form. Laboratory and radiology fees are paid at Medicaid's fee schedule. Revenue codes that are not on the *Included In* list are paid at the outpatient reimbursement rate on file.

3.8.4 Bundling

Charges for ASC claims should not be bundled under revenue code **490**. All charges should be listed under the appropriate revenue codes as on outpatient claims. Charges denied as *Included In* are calculated as part of the tally in determining payment at the time cost settlement occurs.

3.8.5 Dental Procedures

A HC referral is not required for dental procedures performed in a hospital outpatient or ASC setting.

All dental procedures performed in an outpatient or ASC setting must be billed under the CPT code **41899** (Surgical). Prior authorized dental procedures should also be billed with CPT code **41899**.

When billing for dental services performed in the outpatient setting, use bill type **831**, revenue code **490**, and procedure code **41899**.

Oral Surgeons, see *Section 3.3.10.3 Oral Surgeons*, for more information on billing.

3.8.6 Ambulatory Surgical CPT Codes

See the Medicaid ASC fee schedule for a complete listing of approved ASC CPT codes and payment levels at: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3502/DesktopDefault.aspx**.

Consult your *Current Procedural Terminology (CPT) Manual* for complete descriptions of the codes.

3.9 Ambulance Service Policy

3.9.1 Overview

Hospital based ambulance service is payable only if used in the event of an emergency situation or after PA has been obtained from DHW, Medicaid Ambulance Review. Medicaid Ambulance Review manages ambulance transportation services, including PA of non-emergency ambulance transportation and retrospective medical review of emergency ambulance claims.

(208) 287-1157 or (800) 362-7648 (toll free)
Fax: (208) 334-5242 or (800) 359-2236

3.9.1.1 Definition of Emergency Services

Medical necessity is established when the participant's condition is of such severity that use of any other method of transport would endanger the participant's life or health. An emergency exists when the severity of the medical situation is such that the usual PA procedures are not possible because the participant requires immediate medical attention.

3.9.1.2 Definition of Non-Emergency Service

Medicaid defines non-emergency service as scheduled transportation provided when the physical condition of the participant requires ambulance transport and another form of transportation will place the participant's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the participant's home from the hospital.

Transportation of a participant residing in a long-term care facility is the responsibility of the long-term care facility, unless the condition of the participant requires ambulance transport and PA has been obtained. If PA is required, the PA number must be included on the claim or the service will be denied.

3.9.2 Co-Payment for Non-Emergency Use of Ambulance Transportation Services

Idaho Medicaid implemented co-payment provisions of House Bill #663 passed by the 2006 Idaho legislature. Beginning with dates of service on or after February 1, 2007, ambulance providers may bill Medicaid participants a three dollar ($3.00) co-payment for inappropriate ambulance service utilization when the following two conditions are met:

- The Department of Health and Welfare determines that the Medicaid participant's medical condition did not require emergency ambulance transportation.
- The Department of Health and Welfare determines that the Medicaid participant is not exempt from making co-payments according to Federal statute.

The Department of Health and Welfare (DHW) will notify both the ambulance provider and the Medicaid participant on the Notice of Decision letter when a participant may be billed for a co-payment.

Note: Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.

3.9.3 Licensing Requirements

Ambulance services providers must hold a current license issued by Emergency Medical Services (EMS) according to the level of training and expertise personnel maintain, and must comply with the rules governing EMS services. Ambulance services providers based outside the state of Idaho must hold a current license issued by that State's EMS licensing authority. No payment will be made to ambulance services providers that do not hold a current license.

EMS
(208) 334-4000
Fax: (208) 334-4015

3.9.4 Billing Information

Hospital based providers must bill on the UB-04 claim form or the electronic claim using hospital revenue codes **540 - 549**. See *Section 3.7.3 Ancillary Revenue Codes*, for more information.

Both ground and air ambulance services owned and operated by hospitals must bill on the UB-04 claim form or the electronic claim using hospital revenue codes. UB-04 claim forms are available from local form suppliers.

Required attachments include third party EOB for other insurance payments and denials.

3.9.4.1 Third Party Recovery (TPR)

Required attachments to UB-04 claim forms include third party EOB for other insurance payments and denials. If billing electronically, then the attachment is not required. However, the correct ARC codes and other insurance information must be submitted. See *Section 2.4 Third Party Recovery (TPR)*, for information on Medicaid policy for billing all other TPR resources before submitting claims to Medicaid.

3.9.4.2 Medicare Participants

If a participant has Medicare coverage, the provider must first bill Medicare for services rendered. See *Section 2.4 Third Party Recovery*, and *Section 2.5 Crossover Claims*, *General Billing Information,* for billing instructions.

3.9.4.3 Submit the Claim to EDS

Authorized claims are submitted to EDS for payment. The provider's claim form must match the information on the Notice of Decision or claims will be denied.

3.9.5 Covered Services

3.9.5.1 Air Ambulance

Air ambulance services are covered when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential.
- The participant's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance except in emergency situations.

If the aircraft is owned and operated by a hospital, the service must be billed on a UB-04 claim form or the electronic claim using appropriate revenue codes. Air ambulance services not owned by a hospital must bill on the CMS-1500 claim form or the electronic claim using HCPCS procedure codes.

3.9.5.2 Ground Ambulance

Ambulance services, which are owned and operated by a hospital, must be billed on the UB-04 claim form or the electronic claim using hospital revenue codes. All other ambulance providers must submit claims on the CMS-1500 claim form or electronic claim using HCPCS procedure codes.

3.9.5.3 Waiting Time and Extra Attendants

Waiting time and extra attendants are not paid unless medically necessary, and authorized by Medicaid Ambulance Review. Waiting time must be physician ordered.

3.9.5.4 Oxygen

Medicaid pays for oxygen when used by the participant during transport. This rate includes disposables such as masks or cannula.

3.9.5.5 Multiple Runs in One Day

When the ambulance has transported a participant, returned to the base station, and transported the same participant to another facility, two base rate charges will be allowed.

When the ambulance has transported a participant, the same participant is transferred to another facility, and the ambulance has not returned to the base station, one base rate will be allowed. Waiting time must be included in the base rate.

When the ambulance responds to a participant's home for two emergencies in a single day and transports the participant to the hospital twice, two base rates will be allowed. Indicate on the claim in the comments field that there were multiple runs on the same day.

3.9.5.6 Round Trip

Medicaid allows round trip charges when a hospital inpatient goes to another hospital to obtain specialized services not available in the original hospital and the referral hospital is the nearest one with such facilities.

Medicaid places restrictions on round trip charges, depending on whether the ambulance returns to the base station between trips.

- When the ambulance does not return to base station, bill for one base rate, including waiting time, limited to one and one-half (1½) hours.
- When the ambulance does not wait but returns to the base station between trips, bill for two base rates.

3.9.5.7 Physician in Attendance

In some situations a physician in attendance will be justified. When a physician is in attendance, the documentation should justify the necessity and indicate the specialty type of the physician. Physicians are responsible for billing their own services.

3.9.5.8 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when the requested service has been prior authorized by Medicaid Ambulance Review. Payment for any non-covered service is the responsibility of the facility.

3.9.5.9 Trips to Physician's Office

Ambulance service from a participant's home to a physician's office is not covered unless it has been prior authorized by Medicaid Ambulance Review.

3.9.5.10 Treat and Release, and Respond and Evaluate

A treat and release payment may be authorized if the participant is treated at the scene and not transported. Disposable supplies used at the scene are also covered. Medicaid Ambulance Review may downgrade a claim to a non-emergency service if the participant was transported but the transport has been determined not medically necessary.

A non-emergency service may be authorized if the ambulance responds to the scene and evaluates the participant, but no treatment or transport is necessary. Medicaid Ambulance Review may also downgrade a claim to a non-emergency service if the participant was transported but the transport has been determined not medically necessary.

3.9.5.11 Deceased Participants

Ambulance service for deceased participants is covered when documented in the run sheet as follows:

- If the participant was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the participant was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.

Contact Medicaid Ambulance Review for questions about:

- Notice of Decision.
- Reconsideration of decision.
- Appeal process.

(208) 287-1157 in the Boise calling area

(800) 362-7648 (toll free)

3.9.6 Reimbursement Information

3.9.6.1 Customary Fees

Medicaid reimburses hospital owned and operated ambulances on a cost basis and all other ambulance providers on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Transportation of nursing home participants is considered part of the content of nursing home care and therefore is the responsibility of the nursing home, unless the condition of the participant requires ambulance transport. All non-emergency transports must be prior authorized by Medicaid Ambulance Review. See *Section 3.9.7 Ambulance Service Prior Authorization (PA)*, for more information.

See *Section 2.5 Crossover Claims*, *General Billing Information*, for information on crossover claims.

3.9.6.2 Base Rate for Ambulances

Levels of Service: There are three levels of service that providers may request when seeking reimbursement for patient transports, and treat and release (non-transport):

- Non-emergency services, including treat and release or respond and evaluate.
- Emergency services.
- Neonatal ambulance services.

When reviewing and authorizing a particular level of service Medicaid Ambulance Review must consider if either:

- An emergency existed.
- If the patient was transported/not transported, the services rendered were medically necessary.

Separate fees are allowed for supplies, oxygen, pharmacy items, and electrocardiogram (EKG) (see *Section 3.7.3 Ancillary Revenue Codes*, for revenue codes **540** - **549**). Mileage must be included in the base rate.

3.9.7 Ambulance Service Prior Authorization (PA)

Medicaid Ambulance Review operates a transportation management system for medical transportation services. This includes PA of non-emergency ambulance and the retrospective medical review of emergency transport by ambulance.

Any Medicaid claim for ambulance services must include an authorization number from Medicaid Ambulance Review when submitted to EDS for payment.

(208) 287-1157 in the Boise calling area
(800) 362-7648 (toll free)
Fax: (208) 334-5242 or (800) 359-2236

3.9.7.1 Non-Emergency Ambulance Transportation

Hospital-based ambulances must include the PA number in field **63** of the UB-04 claim form as an outpatient claim, or in the appropriate field of the electronic outpatient claim form. Run sheets are not required when the claim is submitted to EDS. See *Section 3.9.4 Billing Information* and *Section 3.7.3 Ancillary Revenue Codes*, for more information on the revenue codes required for ambulance services.

3.9.7.2 Emergency Transportation

Fax or mail notice of emergency and non-emergency transports to Medicaid Ambulance Review at:

Division of Medicaid
Ambulance Review
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 334-5242 or (800) 359-2236

3.9.8 Requests for Retrospective Review/Authorization

To obtain a retrospective authorization for emergency services and/or transportation, fax or mail a copy of the completed claim form and patient care record to Medicaid Ambulance Review. Attach a copy of the third party EOB if applicable.

Upon receipt of the completed claim information:

- The appropriateness of the revenue code billed is evaluated and may be downgraded to a non-emergency service.
- The claim is evaluated for appropriate treatment and disposable supply codes as requested. All requested supplies and treatment must be medically appropriate for the medical condition supported by the patient care record.
- Any potential denial or downgrade of the requested service is referred to an on-call emergency medicine physician for review prior to the denial or downgrade.

An approved or denied decision is submitted to EDS and a Notice of Decision is generated to the participant and the ambulance provider. The Notice of Decision will include any PA numbers, procedure codes, dates of service, and number of units necessary for billing. Questions regarding the Notice of Decision should be directed to Medicaid Ambulance Review. Fax or mail notice of emergency and non-emergency transports to Medicaid Ambulance Review at:

Division of Medicaid
Ambulance Review
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 334-5242 or (800) 359-2236

3.9.9 Requests For Reconsideration (Appeals)

Providers may appeal a PA decision made by Medicaid Ambulance Review by following these steps:

Step 1 Carefully examine the Notice of Decision for Medical Benefits to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on

the next line in the notice. If the provider determines that an inappropriate denial of service has occurred, the next step is to submit a written Request for Reconsideration.

Step 2 Prepare a written Request for Reconsideration, including any additional or extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review.

Step 3 Submit the written request directly to Medicaid Ambulance Review within 28 days of the date on the Notice of Decision for Medical Benefits.

Mail the Request for Reconsideration to:

Division of Medicaid
Ambulance Review
PO Box 83720
Boise, ID 83720-0036

Step 4 Medicaid Ambulance Review will return a second Notice of Decision for Medical Benefits to the requestor within 30 days of receipt of the provider's Request for Reconsideration. If the reconsidered decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to DHW.

3.9.10 Requests For Reconsideration (Appeals) of Medicaid Ambulance Review

To submit a written request for an appeal of the Medicaid Ambulance Review decision, follow the steps below. Providers may fax all documentation but the fax must be followed with copies of original documents in the mail.

- Prepare a written request for an appeal that includes:
  - A copy of the Notice of Decision for Medical Benefits from Medicaid Ambulance Review.
  - A copy of the Request for Reconsideration from the provider.
  - A copy of the second Notice of Decision for Medical Benefits from Medicaid Ambulance Review showing that the request for reconsideration was performed.
  - An explanation of why the reconsideration remains contested by the provider.
  - Copies of all supporting documentation.
- Mail the information to:

  Hearings Coordinator
  Idaho Department of Health & Welfare
  Administrative Procedures Section
  PO Box 83720
  Boise, ID 83720-0036

3.10 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to participants and providers who meet the criteria specifically identified in *Medicaid Basic Plan Benefits IDAPA 16.03.09.640 Diabetes Education and Training Services – Definitions through 645 Diabetes Education and Training Services – Provider Reimbursement. Providers must operate an American Diabetes Association (ADA)* recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a recognized program in a physician's office or outpatient hospital. Their counseling services must be billed under the provider number of their employer, i.e., the hospital or physician's clinic provider number.

3.10.1 Individual Counseling - Diabetes/Education Training

For reimbursement, bill with procedure code **G0108** (1 Unit = 30 Minutes), in co njunction with revenue code **942** to comply with Medicare billing instructions. The CDE's services are to augment and not be substituted for the services a physician is expected to provide to diabetic participants. Medicaid allows only 12 hours per participant, every five years, for individual counseling.

3.10.2 Group Counseling - Diabetes Education/Training

For reimbursement, bill with procedure code **G0109** (1 Unit = 30 Minutes), in conjunction with revenue code **942** to comply with Medicare billing instructions. Only hospitals operating an ADA recognized program may bill for group counseling. Group counseling for diabetes education and training is limited to 24 hours, per participant, every five years.

3.11 Dietitian Service Policy

3.11.1 Overview

Dieticians may bill the Medicaid program directly for nutritional services provided to pregnant women (PW) and children. Nutritional services include intensive nutritional education, counseling, and monitoring. Either a registered dietician must render these services or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association (ADA). If a dietician works for a hospital, the hospital bills Medicaid directly for the services.

3.11.2 Covered Services

3.11.2.1 Pregnant Women (PW) Services

Nutritional services for women enrolled in the PW Program. All listed criteria must be met:

- Must be ordered by the participant's physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.

Extend only through the 60th day after delivery.

3.11.3 Limitations

3.11.3.1 Pregnant Women PW

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*.

Note: If a dietitian works for a hospital, then the hospital bills directly for this service.

3.11.3.2 Children (up to 21st birthday)

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*.

Children may receive additional visits when medically necessary and prior authorized.

Mail PA request to:
Division of Medicaid
Medical Care Unit
PO Box 83720
Boise, Idaho 83720-0036

3.11.4 Procedure Codes

Service	Code	Modifier	Description
PW nutritional services	**S9470**	**U5**	Nutritional counseling, dietician Visit. The **U5** (PW) modifier is required when reporting dietician services for the PW Program.
Children's nutritional services	**S9470**	No modifier required	Nutritional counseling, dietician visit.
Education/Training	**942**	HCPCS	For diabetes education and training, use HCPCS **G0108** (Individual Counseling) and **G0109** (Group Counseling). For pregnant women (PW) or Early Periodic Screening Diagnosis and Treatment (EPSDT) nutritional services use **S9470**. See *Section 3.10 Diabetes Education and Training,* or *Section 3.11 Dietician Service Policy,* for more information.

3.12 Claim Billing

3.12.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

- To submit electronic claims, use the HIPAA compliant 837 transaction.
- To submit claims on paper, use original red UB-04 claim forms available from local form suppliers.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.12.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions* (*PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See *Section 2 General Billing Information,* for more information.

3.12.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional Claims.

Surgical Procedure Codes, ICD-9-CM Volume 3: Idaho Medicaid allows 25 surgical procedure codes on an electronic HIPAA 837 Institutional Claim.

Modifiers: On an electronic HIPAA 837 Institutional Claim, where revenue codes require a corresponding HCPCS or CPT code, up to four modifiers are allowed. (On a paper claim, only two modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the **TC** modifier must be submitted.

Type of Bill (TOB) Codes: Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of six. Electronic HIPAA 837 Institutional claims with valid TOB codes, not covered by Idaho Medicaid, are rejected before processing.

Condition Codes: Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional Claim.

Value, Occurrence, and Occurrence Span Codes: Idaho Medicaid allows 24 value, 24 occurrence, and 24 occurrence span codes on the electronic HIPAA 837 Institutional Claim.

Diagnosis Codes: Idaho Medicaid allows 27 diagnosis codes on the electronic HIPAA 837 Institutional Claim.

Ambulance Services: Idaho requires the following information when submitting an electronic HIPAA 837 Institutional Claim for ambulance services.

- Transport code.
- Transport reason code.
- Transport distance.
- Condition code.

- Round trip purpose - when the transport code is equal to X for round trip.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for institutional services.

3.12.3 Guidelines for Paper Claim Forms

3.12.3.1 How to Complete the Paper Claim Form

These instructions support the completion for the UB-04 claim form only. The following will speed claim processing:

- Provider numbers submitted on the paper UB-04 claim form must be the 9-digit Idaho Medicaid billing provider number. Paper claims submitted with only the NPI will be returned to the provider. Claims submitted with both the NPI and the Medicaid provider number will be processed using the Medicaid provider number only.
- Complete all required areas of the UB-04 claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean, use correction tape to cover errors.
- A maximum of 22 line items, per claim can be accepted. If the number of services performed exceeds 22 lines, prepare a new claim form and complete the required data elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- Do not use staples or paperclips for attachments, stack them behind the claim.
- Do not fold the claim form(s), mail flat in a large envelope (recommend 9 x 12).

See *Section 3.12.3.3 Completing Specific Fields on a Paper Claim Form*, for instructions.

3.12.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.12.3.3 Completing Specific Fields on a Paper Claim Form

See *Section 3.12.3., Sample Paper Claim Form*, to see a sample UB-04 claim form with all fields numbered. Provider questions regarding institutional policy and coverage requirements are referred to, *IDAPA 16.03.09 Medicaid Basic Plan Benefits*, and *16.03.10 Medicaid Enhanced Plan Benefits*.

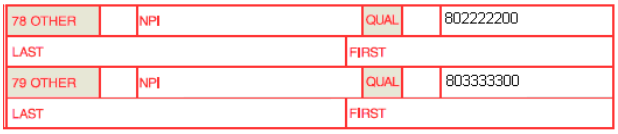
The following numbered items correspond to the UB-04 claim form. Consult the, Use column to determine if information in any particular field is required and refer to the, Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Blank Field	Required	Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the provider master file.
3a	Pat CNTL #	Desired	The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.
3b	Med Rec #	Desired	The number assigned to the participant's medical/health record.
4	Type of Bill	Required	Enter the 3-digit code from the *UB-04 Manual*. Adjustment Type of Bill Codes are not appropriate when submitting services on paper claim forms for Idaho Medicaid billings. See *Section 3.1.4 Type of Bill Codes*.
6	Statement Covers Period From/Through	Required	The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY. Administratively necessary days (AND): The, From Date is the month, day, and year the participant was discharged from inpatient acute level of care. Outpatient claims: Outpatient claims must indicate the specific dates in field **45** to eliminate duplicate appearing services. Late or additional charges: Inpatient claims - see field **42** for information. Outpatient claims - see field **45** for information. Accommodation charges: Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a participant is discharged under normal circumstances. Although there is no reimbursement for the discharge day; that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation. Extended hospitalization: If a participant requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code **30** in field **17**. This code tells the system that the participant is still a patient and to reimburse the hospital for the last day on the claim. Example: Claims for three sequential interim bills would have the following sequential date and patient status format: Patient Claim / From / To Date / Status / Days Billed 1 / 01/15 - 01/31/04 / 30 / 17 2 / 02/01 - 02/15/04 / 30 / 15 3 / 02/16 - 02/24/04 / 01 / 8 **Note:** If patient status **30** is not used, the accommodation rate formula will not balance and the system will deny the claim.
8a	Patient Name	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000.
8b	Blank	Required	Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Description
12	Admission Date	Required, inpatient, hospice, nursing home	Enter the month, day, and year the participant entered the facility. (This date will be the same on all submitted claims and will not necessarily be the same as the date found in field **6**.) Enter as MMDDYY or MMDDCCYY.
13	Admission Hr	Required, inpatient, outpatient, hospice, nursing home	Enter the 2-digit hour the participant was admitted for inpatient or outpatient care in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m.
14	Admission Type	Required, Inpatient	Use the priority admission codes in the *UB-04 Manual*. Only codes **1**, **2**, **3**, and **4** are allowed by Medicaid.
15	Admission SRC	Required, Inpatient	Use the 1-digit source of admission codes **1** - **8** in the *UB-04 Manual*. Medicaid does not accept code **9**. Not Required for outpatient claims.
16	DHR	Required, Inpatient	Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Desired for outpatient claims.
17	STAT	Required, inpatient	Patient Status: Use one of the codes listed in, *Section 3.1.5 Patient Status Codes*, to indicate patient status. Not required for outpatient claims.
18 - **28**	Condition Codes	Desired	Use the codes listed in the *NUBC Billing Manual*.
31 - **34**	Occurrence Code/Date	Desired	Use one of the codes listed in the *NUBC Billing Manual* and enter the date of the occurrence.
35 - **36**	Occurrence Span	Desired	Use the date span related to the Occurrence Code entered in the preceding field.
39 - **41**	Value Codes Amount	Required, ANDs	See *Section 3.5 Administratively Necessary Days (AND),* for directions on how to bill AND. Covered Days: Required for inpatient claims only **80** – Covered Days. **81** – Co-Insurance days. (Cross over claims only.) **82** – Lifetime Reserve Days. (Cross over claims only.)
42	REV CD	Required, inpatient	All revenue codes are accepted by Idaho Medicaid, however, not all codes are payable. Revenue code **001** is no longer to be used for the total charges. The total charges are to be entered in the designated box on line **23**. Inpatient claims (late, additional, or denied charges): 1. Late or additional charges where the revenue code was not on the original claim: Bill on a new claim for only the late or additional charges with the accommodation rate and revenue code**.** Note in field **80** *Billing for late charges*. 2. Late or additional charges where the revenue code was paid on the original claim: Submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: Bill the denied line with the accommodation rate and revenue code on a new claim. Note in the field **80** *Billing for denied lines.* Outpatient claims (late, additional, or denied charges): For instructions for outpatients billing, refer to field **45**.

Field	Field Name	Use	Description
44	HCPCS/RATE/ HIPPS Code	Required, if applicable	All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with CPT or HCPCS notation in, *Section 3.5.5 Billing Procedures,* and *Section 3.7.3 Ancillary Revenue Codes*. If the code requires a modifier, put one space between the code and modifier. Example: Positron emission tomography (PET) scans require a HCPCS code and the **TC** modifier (i.e. G0222 TC). **Note:** HIPPS codes are not billable to Idaho Medicaid.
45	Serv Date	Required, outpatient	Required for all outpatient services. Enter the specific date of service for all charges or the claims will be denied. Outpatient claims (late, additional, or denied charges): 1. Late or additional charges outside the date span in field **6**. Bill on a new claim form. Note in field **80** *Billing for late charges*. 2. Late or additional charges within the date span in field **6** with the same revenue codes and the same specific date. Submit on an adjustment request form. 3. Late or additional charges within the date span in field **6** with different revenue codes. Bill on a new claim form. Note in field **80** *Billing for late charges*. 4. Resubmit all denied charges on a new claim.
46	Serv Units	Required	Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered. Example: Accommodation Code = Number of days the level of service was rendered. **Note:** It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a participant in the hospital receives three different levels of care, each must be billed on a separate line. Example: Level I = $100 x 3 units of service Level II = $150 x 2 units of service Level III = $200 x 1 unit of service
47	Total Charges	Required	Total charges: Bill total covered charges only. Ancillary charges formula: Revenue Code Fee X Units of Service Total Charges Accommodation rate formula: Daily Rate X Units of Service Total Charges
50 A	Payer Name	Not required	Payer A: If Medicaid is the only payer, enter, Idaho Medicaid in field **50A**. If there is one other payer in addition to Medicaid, enter the name of the group or plan in field **50A** and enter, Idaho Medicaid in field **50B**.
50 B	Payer Name	Not required	Payer B: If there are two other payers in addition to Medicaid, enter the names of the group or plan in fields **50A** and **50B** and enter, Idaho Medicaid in field **50C**.
50 C	Payer Name	Not required	Payer C: If there are two other payers in addition to Medicaid, enter, Idaho Medicaid in field **50C**.

Field	Field Name	Use	Description
51 A - C	Health Plan ID	Not required	Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A** - **C**. Example: In field **50A**, Medicare is entered as the Payer. In field **51A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the payer. In field **51B** enter the identification number used by Healthy Home Insurance Company for the provider.
54	Prior Payments	Required, if applicable	Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.
55	Est. Amount Due	Not required	Total charges due (total from field **47**) minus prior payments (total from field **54**).
57 A - C	Other PRV ID	Required	Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in field **50 A** - **C**. Example: In field **50A**, Medicare is entered as the payer. In field **57A**, enter the identification number used by Medicare for the provider. Example: In field **50B**, Healthy Home Insurance Company is entered as the payer. In field **57B** enter the identification number used by Healthy Home Insurance Company for the provider.
58	Insured's Name	Desired	If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. **Example:** Medicaid provider information is entered in **50A**, and then the Medicaid participant data must be entered in **58A**.
59	P. REL	Desired	Patient's relationship to insured, see the *UB-04 Manual* for the 2-digit relationship codes.
60	Insured's Unique ID	Not required	Enter the 7-digit Medicaid identification (MID) number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	Group Name	Not required	If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	Insurance Group No.	Not required	If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	Treatment Authorization Codes	Required, if applicable	Prior authorization (PA) number for AND, or retrospective reviews or PA number for ambulance run by Emergency Medical Services (EMS).
66	DX	Required	Enter the ICD-9-CM code for the principal diagnosis. Do not use **E** diagnosis codes.

Field	Field Name	Use	Description
68 - 73	Blank Field/ Admit DX/ Patient Reason DX/PPS Code/ ECI/Blank Field	Desired	Use the ICD-9-CM code(s) describing the secondary diagnoses. Do not use **E** diagnosis codes.
69	Admit DX	Required, inpatient	Admitting Diagnosis Code. Desired for outpatient claims. Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the *Qualis Health Handbook*.
72	ECI	Desired	Enter the ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (**E** codes are not used on the UB-04 claim form.)
74	Principal Procedure Code/Date	Desired	Enter the ICD-9-CM code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used.
74 a - e	Other Procedure Code/Date	Desired	Enter all secondary surgical, diagnostic or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
76	Attending	Required	The Idaho Medicaid provider number is to be entered in the fourth (last) box after, **76** Attending. Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.
78 - 79	Other	Required, Healthy Connect-ion (HC)	Other Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box of **78** or **79,** Other. Required for HC participants referred to the hospital by the primary care provider (PCP). Enter the PCP 9-digit numerical referral number in field **78** or **79**. Do not include the letters HC before the number. If field **78** is blank the information in field **79** will populate the referral number field. 
80	Remarks	Not required	Remarks: Enter information when applicable. For participants who have only Medicare Part A, enter, *Participant has Part A only*. Other information to be entered may include: Proof of timely billing Internal Control Number (ICN), third party injury information, or no third party liability coverage.

3.12.3.4 Sample Paper Claim Form